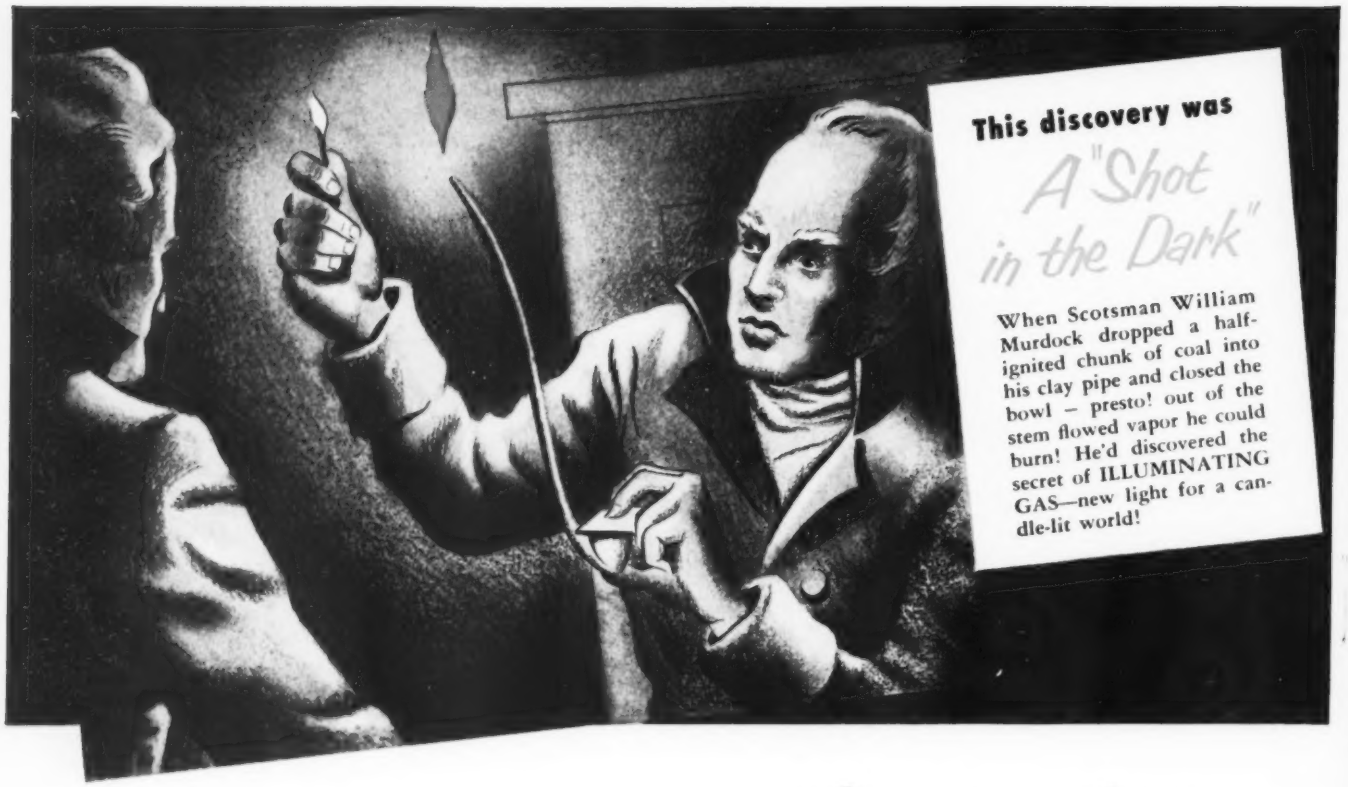
The Modern Hospital

SEPTEMBER 1954

Psychological Study of the Hospital-Patient Relationship • Facilities for Care of Chronic Disease • Malpractice Insurance • Small Hospital Recovery Room • Report of the Study on Education of Administrators • Hospitals and the Press



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The Modern Hospital

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AMONG THE AUTHORS


C. H. Hottum Jr.

C. H. Hottum Jr. is assistant administrator at the Methodist Hospital, Memphis, Tenn., whose business office layout is described in the article on page 61. A certified public accountant, Mr. Hottum is a director of the American Association of Hospital Accountants, and past president of the Tennessee chapter of the association. He has been assistant administrator of Methodist Hospital since 1945. Prior to that time, he had several years of public accounting experience in business. He is a member of the American College of Hospital Administrators.


Sylvia R. Mitchell

Sylvia Roletto Mitchell is chief dietitian at Herrick Memorial Hospital, Berkeley, Calif., whose food service operation is described in the article on page 108. Mrs. Mitchell has been chief dietitian at the hospital for the last seven years, a period which covered the planning, construction and occupation of a new kitchen accommodating the expanded hospital and providing for future development. Prior to her appointment at Herrick, she was a staff dietitian at the University of California Hospital and at Mount Zion Hospital, San Francisco. She also served as staff dietitian at a summer camp for diabetic children. Mrs. Mitchell received her bachelor's degree, with major emphasis in foods and nutrition, from the University of California, with a certificate for a year's postgraduate study in hospital dietetics. She is a member of the American Dietetic Association, and has been chairman of the San Francisco area of the California Dietetic Association. For the last three years, Mrs. Mitchell has been dietetic consultant for a special study of obesity carried on at Herrick Hospital under the sponsorship of the California Public Health Department. She is also a leader of weight control classes conducted by the Contra Costa County Heart Association.


John F. Wight

John F. Wight, co-author with Mrs. Mitchell of the article describing the food service operation at Herrick Memorial Hospital, is assistant administrator of the hospital. A graduate of the University of California, Mr. Wight has been at Herrick Hospital for the last six years. He is president-elect of the Hospital Economics Section of Northern California, chairman of the personnel section of the Association of Western Hospitals, a member of the committee on sections of the Association of Western Hospitals, and is also a member of the workshop committee of the administrative assistants section of the Association of Western Hospitals.

Among the other authors in this issue are: **Dwight W.** and **Richard C. Sleeper,** insurance consultants, and, respectively, chief consultant and associate consultant of the Insurance Buyers Council, Harwich Port, Mass.; **Robert Redfield,** professor in the department of anthropology, University of Chicago; **Richard E. Burgess,** director of control at the research and production laboratories of Don Baxter, Inc., Glendale, Calif.; **Dr. Lee O. Garber,** associate professor of education, University of Pennsylvania, Philadelphia, and **Susan S. Jenkins,** executive secretary of the Kansas City Area Hospital Council, Kansas City, Mo., and assistant to the director of the Blue Cross Blue Shield plan there.

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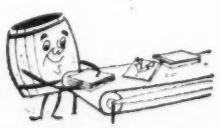

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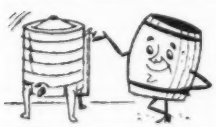

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Roving Reporter

Hospital Architect Honored by Queen

MELBOURNE, AUSTRALIA.—Arthur G. Stephenson of the Melbourne firm of Stephenson & Turner, hospital architects, was made a Knight Bachelor in the Queen's birthday honors list published last month, E. E. Harvie, a member of the firm, reported here.

Mr. Stephenson was also admitted to the Order of St. Michael and St. George in the Queen's birthday honors of 1953, Miss Harvie said, and, on the occasion of Queen Elizabeth's visit to Melbourne this year, he was awarded the Royal Gold Medal of the Royal British Institute of Architects. The medal was presented by Queen Elizabeth personally at a private audience at Government House, Melbourne.

Sir Arthur Stephenson, C.M.G., M.C., F.R.I.B.A.

The distinguished Australian hospital architect has been admitted to the Order of St. Michael and St. George, created a Knight Bachelor, and awarded the Royal Gold Medal of the Royal British Institute of Architects.

A distinguished hospital architect who has built many of the great hospitals of Australia, Mr. Stephenson has visited America frequently and is well known to American hospital architects and administrators. A description of the honors he has received, and the manner in which they were presented, as related by Miss Harvie, follows:

"Twice a year, at New Year's and on the Queen's birthday, honour lists are issued. Recommendations are made by the various different governments in the British Commonwealth to the government officcs in London, proposing that different people should have some public recognition for their services to the community. These may range all the way down from an Order of Merit (a very rare honour) for the chief justice of the country to a medal for the housekeeper who has been at Government House for 30 years, or the sergeant-at-arms at Parliament House. Any contribution to the community can be recognized, particularly philanthropic ones, but also outstanding contributions in the arts, saving of lives, scientific discoveries, explorations and so on. There are different types of recognition appropriate to different services.

"In the Queen's Birthday Honours in 1953 Mr. Stephenson was admitted to the 'most distinguished' Order of St Michael and St. George. (Some orders are described properly as 'most eminent,'

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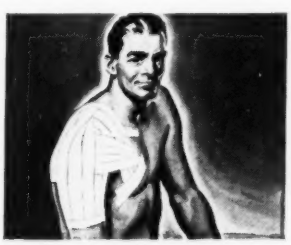

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'most exalted,' 'most honourable' etc.) This order has three different classes —Knights Commander, Knights, and Companions. The two first have the title of 'Sir,' and the third carries no title, but the holder uses the letters C.M.G. after his name. Mr. Stephenson was admitted to this third class. Each of the principal orders of knighthood have a chapel in one of the principal cathedrals of royal chapels in Great Britain — the Order of the Garter at the Royal Chapel at Windsor, the Order of the Thistle at St. Giles, Edinburgh, and so on. The Order of St. Michael and St. George has a chapel in St. Paul's, London.

"At Christmas it was announced that the Royal Gold Medal of the Royal British Institute of Architects had been awarded to Mr. Stephenson. There are gold medals awarded annually by the sovereign to people who have made outstanding contributions in different fields of science or arts, the recommendations coming from different royal societies or institutes. The gold medal awarded to a distinguished architect, or man of science or letters, who has designed or executed a building of high merit, or produced work tending to promote or facilitate the knowledge of architecture or various branches of science connected therewith, was first awarded in 1848. It is regularly awarded to foreigners as well as to British subjects. Americans who have received it are Charles McKim of McKim, Meade and White in 1903, Thomas Hastings (presumably Carrere and Hastings) in 1922, and Frank Lloyd Wright in 1941 and Eliel Saarinen in 1950. This is the first time it has been awarded to an Australian, the Queen's visit undoubtedly turning English eyes toward the Pacific.

"The customary method of award is for the president of the Royal British Institute of Architects to give it to the recipient on behalf of the Queen at a meeting in London, when the recipient is presented to him by two other Royal Gold Medalists.

"In Australia there are no other Royal Gold Medalists, and the Queen was coming to Australia. This medal was presented for the first time by the sovereign personally, at a private audience at Government House, Melbourne, being, so far as we know, the only *private* audience of the tour.

"The medal of the Commander of St. Michael and St. George was presented at a public audience in Melbourne a few days after, when a large number of other decorations were conferred.

"That sounds like enough doesn't it? But no. In the Queen's birthday honours this month Arthur Stephenson is created a Knight Bachelor. This means that in conversation he is now addressed as Sir Arthur. His full titles are Sir Arthur Stephenson, C.M.G., M.C., F.R.I.B.A. The M.C. is the Military Cross which he won in the first world war when he was a captain of Pioneers in France, with the Australian forces.

"A Knight Bachelor does not belong to any particular order of knighthood, and the title is purely an honour and is not hereditary.

The Order of St. Michael and St. George, to which he now belongs as a Companion, was founded in 1818 originally for awards in connection with the Ionian Isles, Malta and the Mediterranean, but has since been very generally used for honours awarded to different parts of the British Commonwealth."

Reader Opinion

Why the Dress Doesn't Fit

Sirs:

I was interested in reading Mr. Blumenkrantz's article, "The Hospital Has a New Dress," in your April issue, and his critical attitude toward some of the interior design aspects of a hospital in which he recently was a patient. Although my sympathy for Mr. Blumenkrantz's inconveniences is extended, I do feel that his emphasis was in the wrong direction.

One does not have to make a choice between the caster on the bedside table and the Van Gogh. You can have both. It has been our experience in interior planning for institutions that the choice of correct materials and equipment is a matter of know-how more frequently than cost. As an example, the small tiles that Mr. Blumenkrantz claims are so difficult to clean are probably more expensive than the type of floor that he would suggest for the practical pantry or utility room.

Unfortunately, in spite of the fact that hospital after hospital has similar problems, there seems to be lacking a clearinghouse for the study, collection and dissemination of the necessary interior planning advice. There should be an efficient agency to study equipment and structural problems that continually repeat themselves in the hospital. An example of areas for study would be the development of a satisfactory patient room door that is small enough for a nurse to handle with her hands occupied carrying trays, and still be large enough to accommodate a bed. Second, a patient room light that is not in the center of the ceiling where a patient is required to look directly at the source of light, but one that is located to offer a wide range of foot-candle control, thus integrating a satisfactory patient reading light, and a satisfactory doctor's examining light.

It seems to me that part of the problem in Mr. Blumenkrantz's hospital is a basically poor selection of furnishings, equipment and a poor general maintenance condition, but the large problem is to have a central agency where hospital planners and administrators can obtain information of all aspects of planning and equipment and benefit by the experience of other institutions.

Leon Gordon Miller
Industrial Designer
Cleveland

Good Public Relations

Sirs:

From time to time I read articles in The MODERN HOSPITAL which are of vital importance to anyone in the hospital field. Many of these articles contain material that would be of interest to the people of the community and an asset in the way of public relations.

Is it possible to obtain permission to let our local newspaper reprint such articles?

If it is possible to obtain such authority would it then be necessary to receive this permission on each article we wanted to publish or would we have a blanket authorization covering any and all items which we might feel would be beneficial to us in our public relations program?

L. L. Landis
Superintendent
Jay County Hospital
Portland, Ind.

Free Choice

Sirs:

I have just read Dr. Bluestone's essay on "Free Choice" with which I agree 100 per cent. This subject needs such frank discussion, for I am sure it has been the source of much hypocrisy among our colleagues. In many instances the doctors who hold "free choice" dearest are the least qualified to meet free competition and actually survive on the absence of free intelligent selectivity in providing medical care.

John D. Stewart, M.D.
Professor of Surgery
University of Buffalo
Buffalo, N.Y.

Sirs:

I can't tell you how much I enjoyed reading Dr. Bluestone's article "How Free Is Free Choice?" in the March issue of The MODERN HOSPITAL.

(*Continued on Page* 12)

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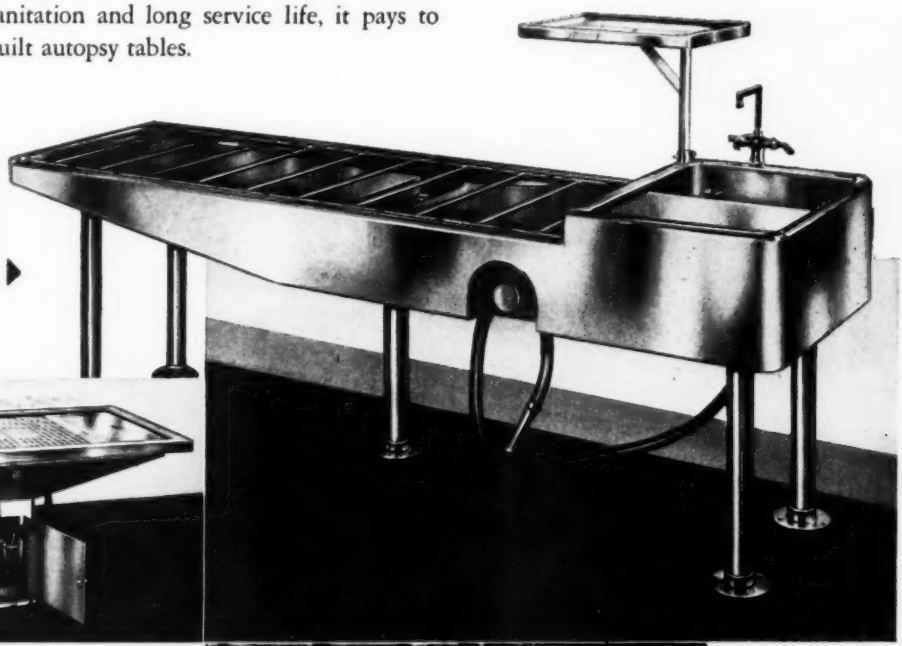

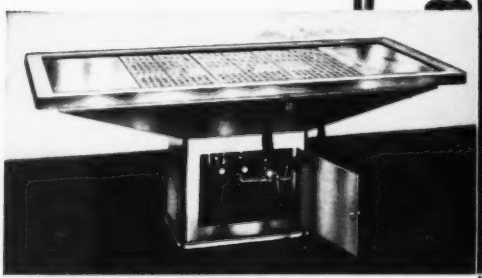

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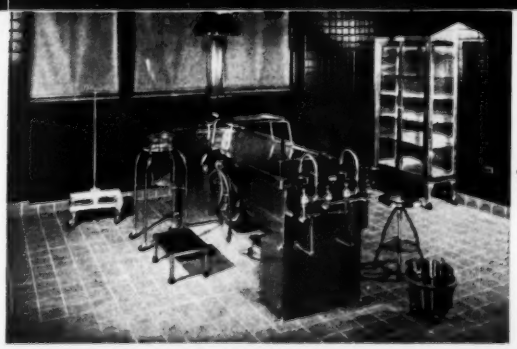

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Among other things, it has set me to wondering whether Dr. Bluestone has already prepared a City of Refuge for himself to escape to after the American Medical Association finishes its Operation Ostracism.

Needless to say, I heartily agree with him.

O. I. Bloom, M.D.
New York City

Sirs:

I have read with considerable interest Dr. Bluestone's article on "How Free Is Free Choice?" For many years I was actively connected with the medical profession, and one of its very foundations in those years was free choice. That the patient often chose the wrong man was inevitable, of course, but one of the dearest things which all sick people cling to is the right to choose their own medical men. This has nothing to do with Dr. Bluestone's fine article. It is just my long experience in the profession which tells me that if Mr. "A" wants Doctor Jones, who is a pediatrist, when he has stomach ulcers, he is going to have Doctor Jones regardless. But personally I have never thought that socialized medicine was the answer.*

Mary Roberts Rinehart
New York City

*I don't mean Dr. Bluestone advocates it, of course!

Sirs:

I enjoyed reading Dr. Bluestone's very thoughtful article "How Free Is Free Choice?" in The MODERN HOSPITAL for March. If reprints are available, I would appreciate having three of them.

As I read his list of examples of situations in which there is now no free choice of physician, I thought of the common situation in many states with respect to occupational injury and disease. With the possible exception of New York and perhaps a handful of other states, in most of the states the injured worker is compelled to go to the doctor designated by the employer or the employer's insurance carrier.

Herbert K. Abrams, M.D.
Health and Welfare Fund
Chicago Office, Theatre, and
Amusement Building Janitors
Union, Local 25
Chicago

Sirs:

The paper "Free Choice" says what every sincere and honest observer of the contemporary scene should state, and I heartily agree that intelligent choice should be substituted for haphazard free choice.

Franz Goldmann, M.D.
School of Public Health
Harvard University
Boston

Prototype Studies

Sirs:

Dr. Louis Block's prototypes have proved to be exceedingly valuable in many instances, for teaching our own classes, for a problem in design for architectural students at Carnegie Tech with which I am assisting, for one proposed hospital, one just ready to open, and one undergoing a program analysis, to all of which we are giving some guidance and consultation. I have heard several other administrators remark about how valuable they are. They really are a most valuable contribution.

John R. McGibony, M.D.
University of Pittsburgh

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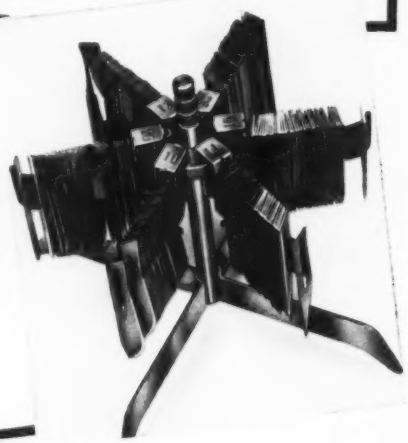

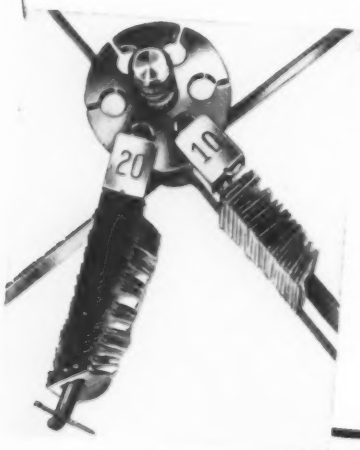

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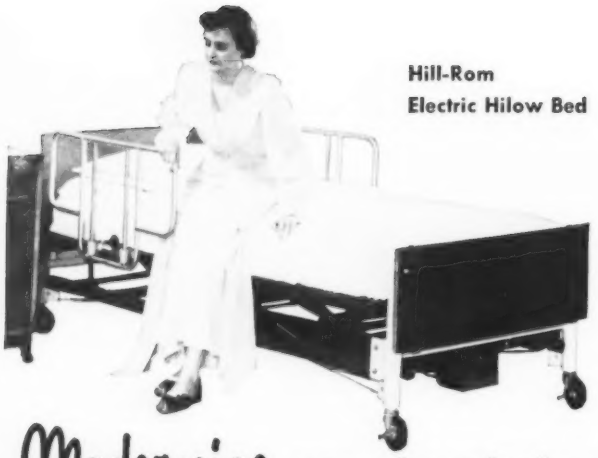

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Modernize your hospital—reduce bed fall accidents—by installing HILL-ROM Hilow Beds

Crank-operated Hilow Bed

The high-low bed is widely accepted today as the mark of a modern hospital, and as one of the greatest safety factors in the prevention of bed fall accidents. Many such accidents that result in serious injury occur when a disoriented patient, in an ordinary high hospital bed, misjudges the distance to the floor, loses his balance, and falls. A high-low bed, in the low position, will prevent many such accidents.

Hill-Rom manufactures two high-low beds. One is manually operated, the other motor driven. The manually operated bed is easily adjusted with a crank located at the foot end of the bed. The friction-free, ball-bearing mechanism makes it easy for the nurse to raise the bed with only a few turns of the crank. The Hill-Rom Electric Hilow Bed is the first bed of its type to be approved by Underwriters' Laboratories, Inc. It is the last word in safety, dependability and long life expectancy.

Complete information on either or both of these high-low beds will be sent on request.

NOW . . . A

high-low bedside unit

HILL-ROM'S Adjustable Height Gammill Table

- combines bedside cabinet and overbed table in one compact unit.
- saves space—saves time—one piece instead of two to move and clean.
- large ball bearing casters for easy movement.
- saves nurse many unnecessary trips.

The Hill-Rom Gammill Table was designed primarily for use with high-low beds, but may also be used with other types of beds. The entire unit—cabinet and overbed table—may be raised or lowered as the patient desires, from a low of 30″ to a high of 45″—merely by turning a crank. It may also be pulled or pushed into any desired position, with the table across or alongside the bed. The Gammill Table brings all the bedside necessities within easy reach of the patient, thereby promoting self help and lightening the nurse's burden. Write for complete information.

HILL-ROM COMPANY, INC., BATESVILLE, INDIANA

PHOTO COURTESY GERBER'S BABY FOODS

Picture of Security

COMPLETE . . . WITH A HOLLISTER Ident-A-Band®

PATENT APPLIED FOR

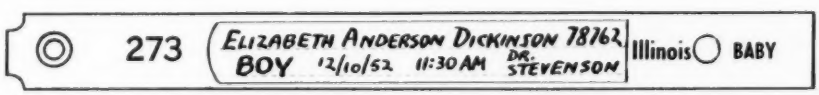
Now . . . security for both family and hospital with this revolutionary new Identification System. Only ONE Ident-A-Band, imprinted with 3 identical numbers, is taken into the Delivery Room. There it is divided into 3 sections, and data cards are inserted. One section is then sealed on Mother's wrist, the other two sections on Baby's wrists, or wrist and ankle.

Mother sees that Baby's number, printed *inside* the neat, comfortable transparent Ident-A-Band, matches her own, each time you bring Baby to her from the Nursery.

Quick, simple, easy to apply . . . leading hospitals in the 48 states and Canada find Ident-A-Band the most *positive* identification available.

Fulfills every requirement of the AHA for positive, correlated, unalterable Mother-Baby identification.

Both Mother's and Baby's band, imprinted with your Hospital's name, city and state, are a lasting reminder of your fine care – proudly displayed in the Baby Book. And you keep Baby's second band as a record.



Just fill out this coupon – we'll send FREE by return mail a complete Ident-A-Band (one section is shown above), together with Data Card and full information.

HOSPITAL _____

ADDRESS _____

BY _____

Franklin C. Hollister Company

GOODWILL BUILDERS FOR HOSPITALS

833 NORTH ORLEANS ST., CHICAGO 10, ILLINOIS

Working Together—

. . . To Build Goodwill for your hospital

More and more hospitals every day are using the new Hollister GoodWill Program described in these two handsome Portfolios:

1. Hollister® *Inscribed*® Birth Certificates

The presentation of this "going home" gift to parents of babies born in your hospital — providing as it does, lifetime proof of the baby's identity — becomes for that family, proof too of your hospital's continuing interest in them.

Actual, full-size birth certificates, and descriptions of many other GoodWill Builders, are included in this big, sixteen-page Portfolio.

2. Matching Birth Announcements

Eight different, and delightful cover designs in pastel colors announce baby's arrival. And, exclusively yours — on the inside fold of each birth announcement — is a beautifully lithograved copy of your hospital's *Inscribed* birth certificate, for the proud parents to sign. A tiny gold seal, embossed with the imprint of a baby's feet "makes it official". Gold "stork" seals for the envelopes give the first hint of the good news inside.

Maternity patients welcome these new and unusual announcements. *And,* most important, your Gift Shop and Women's Auxiliary can start selling them right now at a year-round profit.

Help yourself to better public relations . . . use the Hollister GoodWill Builders illustrated and described in these two Portfolios. Send for both today!

Please send FREE by return mail, the two Portfolios described above, together with full-size Certificates and Announcements.

HOSPITAL _____

ADDRESS _____

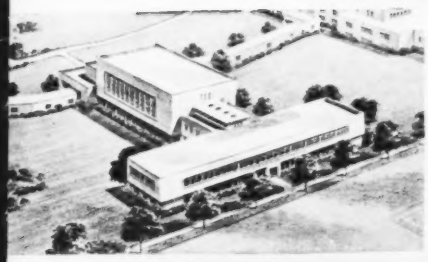
BY _____

Franklin C. Hollister Company

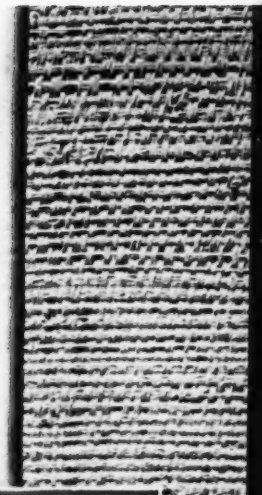
GOODWILL BUILDERS FOR HOSPITALS

833 NORTH ORLEANS ST., CHICAGO 10, ILLINOIS

handsome treatments with **VICRTEX** V.E.F.* **FABRICS**

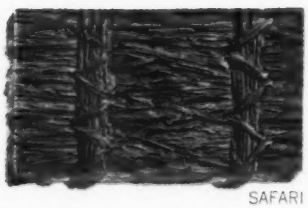


cure high maintenance costs in **HILLSIDE HOSPITAL'S** new $1,000,000 units

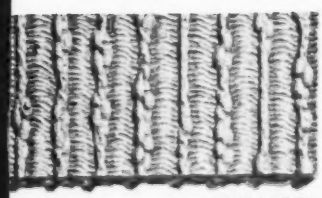


MADAGASKA

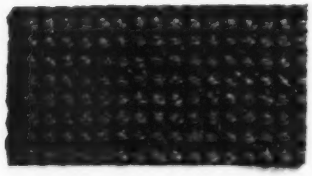
VICRTEX Bambu and Madagaska selected with foresight by Louis Allen Abramson, architect, handsomely complement Auditorium walls in the Elizabeth Lowenstein Clinic (above) and the Israel Strauss Pavilion at HILLSIDE HOSPITAL.



SAFARI



CORONATION



BRUSSELS

At Hillside ... where attractive environment is part of the cure ... where *every* installation must withstand devastating wear ... Architect Louis Allen Abramson specified VICRTEX V.E.F.® FABRICS. Their ability to stand up under hard use, even abuse, is invaluable where accommodations must remain "in service" at all times.

VICRTEX is *at your service* ... indefinitely, uninterruptedly. On walls, VICRTEX *never* needs painting or re-decorating. As furniture upholstery, VICRTEX stands up under heaviest "traffic"—indoors or out!

30 deeply beautiful Tri-Dimensional Designs • 36 fadeproof HOUSE & GARDEN Colors

- PRACTICALLY INDESTRUCTIBLE—Impervious to sun, salt, damp, cold, heat, wind, rain. Cannot snag, chip, crack, peel or scratch. Stain-flame-soil resistant—wipes clean with damp cloth.
- VERSATILE—SOFT—PLIANT—Wall or furniture covering can be draped, folded, pleated—applied to any flat or curved surface.
- SUPPORTED VINYL-FUSED FABRIC needs no extra backing, however used.

WRITE TODAY FOR CARPENTER'S ILLUSTRATED BROCHURE and Swatches. Effect handsome economies on your next commission.

•vinyl electronically fused to firm cotton backing.

L. E. CARPENTER & COMPANY, INC

SALES OFFICE: Empire State Building, New York 1 • Longacre 4-0080 • MILLS: Wharton, New Jersey

Come see, feel VICRTEX at the AHA CONVENTION, BOOTH 1075

#2880 Medicine glasses, with lip
#500 Needle tubes, with constriction
#2900 Medicine glasses without lip
#435 Urine specimen bottle

FOR HOSPITAL GLASSWARE
that is functional, dependable, economical
SPECIFY GLASCO

When you specify Glasco hospital glassware, you are sure of a design that is functional, apparatus that is dependable, a product that is economical.

Glasco glassware is tough. Properly handled, it will provide many years of dependable, year-in, year-out service.

Years of successful use by most of the country's leading hospitals and laboratories confirm the outstanding performance of Glasco. Decide now to give your hospital functional and economical glassware service.

Order Glasco hospital glassware from your hospital supply house, or write to us direct for a free copy of our latest catalog and price listing.

GLASCO PRODUCTS CO.

111 NORTH CANAL STREET, CHICAGO 6, ILLINOIS

these ***KenFlex*** *vinyl tile floors are sure easy to clean*

Here's how New **KenFlex** cuts hospital maintenance expense

KenFlex is amazingly easy and economical to clean *and keep clean.* Greases, oils, acids, alkalis and alcohols can't harm it...dust, dirt and grime can't penetrate or be ground into its colorful, non-porous surface. KenFlex seldom needs scrubbing...never needs waxing except to add extra gloss. Yet, KenFlex...with all its quality advantages...costs far less than many floors that soon fade, pit and scratch... becoming harder, more costly to maintain.

Get full details on KenFlex vinyl tile—and other Kentile, Inc. resilient tile floors—from the Kentile Flooring Contractor listed under FLOORS in the Classified Phone Book, or write the nearest Kentile, Inc. office listed below.

KENFLEX
VINYL TILE ®

KENTILE • KENCORK • KENRUBBER • KENFLEX • KENFLOR

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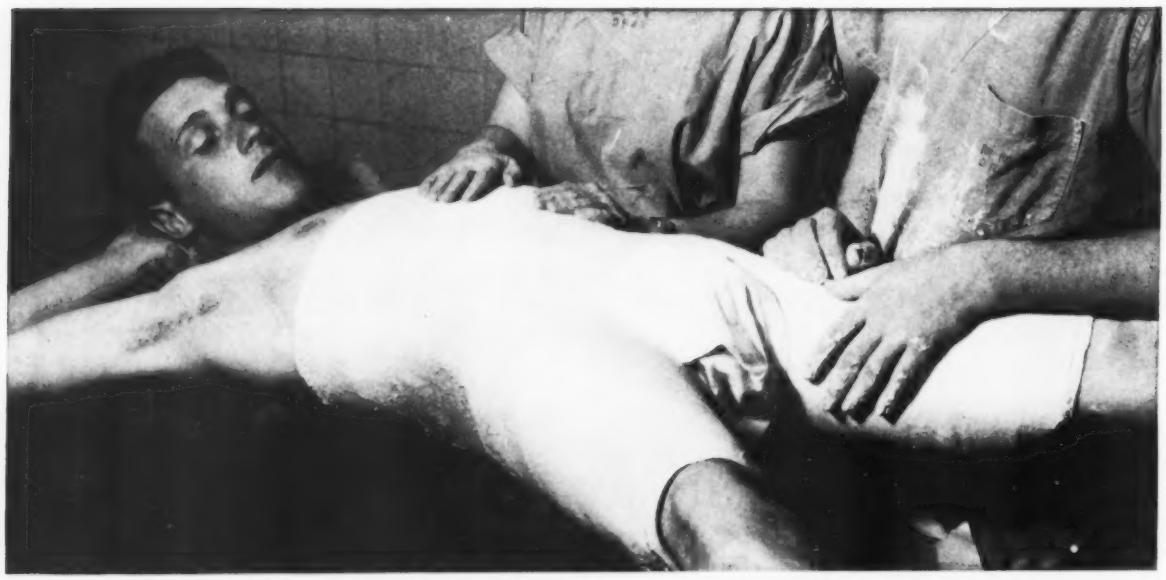
KENTILE, INC., 58 SECOND AVENUE, BROOKLYN 15, NEW YORK • 350 FIFTH AVENUE, NEW YORK 1, NEW YORK • 705 ARCHITECTS BUILDING, 17TH AND SANSOM STREETS, PHILADELPHIA 3, PENNSYLVANIA • 1211 NBC BUILDING, CLEVELAND 14, OHIO • 900 PEACHTREE STREET N.E., ATLANTA 5, GEORGIA 2020 WALNUT STREET, KANSAS CITY 8, MISSOURI • 4532 SO. KOLIN AVENUE, CHICAGO 32, ILLINOIS • 4501 SANTA FE AVENUE, LOS ANGELES 58, CALIFORNIA

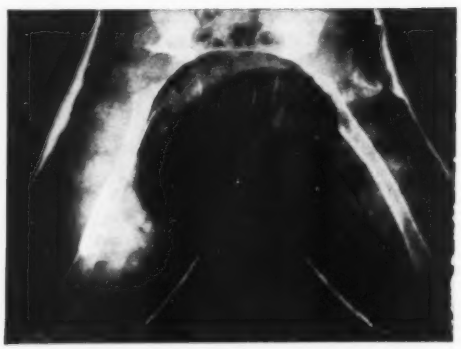
new—ready-to-use MELMAC® BANDAGE saves time, saves labor for surgeons and staff

Now MELMAC® resin, high strength plaster of Paris and catalyst are combined in the new ready-to-use MELMAC BANDAGE. Now, using fewer bandages, your surgeons form stronger, lighter, thinner, water-and-urine-resistant casts and splints for fractures and preoperative, postoperative and corrective surgical procedures. Nothing new for your staff to learn.



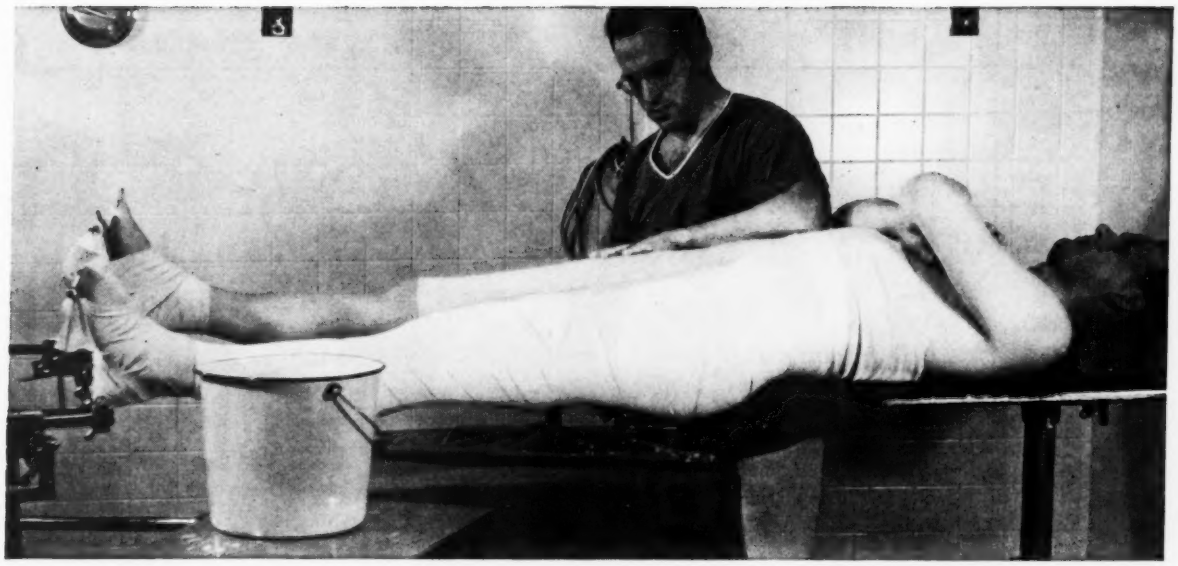
LESS WATCHING, LESS WAITING *by hospital staff because casts of new* MELMAC BANDAGE *quickly give adequate immobilization and support while ordinary casts are still soft and soggy. Patients are moved easily and promptly.*

LESS RECASTING - LESS CARE *by hospital personnel. Casts of* MELMAC BANDAGE *resist wound exudate, urine, water, mold, and are porous. Example: Double Leg Cast in cross-leg skin graft.*

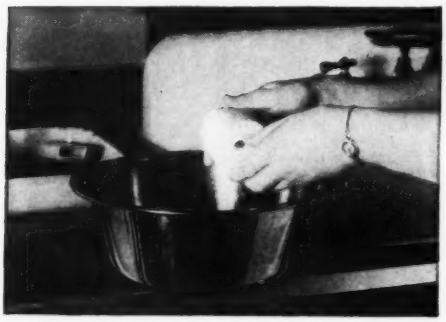


SAVE EXPENSIVE RETAKES. *Thinner cast assures clear x-rays for evaluation of reduction in congenital hip. This is often impossible through thick plaster. Clearer films save technicians' and surgeons' time.*

PATENT APPLIED FOR



LIGHTER CASTS—LIGHTER COSTS. *New casts, about half the weight of bulky plaster, encourage mobilization of joints to prevent stiffness. Patients easier to lift and turn in hospital and at home. Less fatiguing cast often shortens hospitalization.*



1. *Just dip* MELMAC BANDAGES *into tepid water for 5 to 10 seconds and squeeze out thoroughly.* 2. If your usual plaster cast is thick, use about half as many MELMAC BANDAGES. 3. Result: strong, light, thin water-and-urine-resistant cast — no frayed edges. 4. *Same disposal* as with ordinary plaster. 5. Remove thin cast easily with cast cutter, sharp knife or cast saw.

USE ABOUT HALF AS MANY BANDAGES AND SPLINTS . . . available in the following sizes:

	Size	Product No.
Bandages (*rolls*)	2″ x 3 yds.	2122
	3″ x 3 yds.	2123
	4″ x 3 yds.	2164
	4″ x 5 yds.	2124
	6″ x 3 yds.	2166
	6″ x 5 yds.	2126
Splints	3″ x 15″	2133
	4″ x 15″	2134

SENSITIVITY. Since this product may contain traces of formaldehyde, persons who are known to be sensitive to it should be observed closely for dermatitis. Operators using the bandage repeatedly should wear rubber gloves if skin sensitivity exists.

SAVE AGAIN! Bring your old plaster of Paris bandages up to date. Dissolve MELMAC® Orthopedic Composition, a powder, in water in which you wet ordinary plaster bandages and you will have a cast comparable in strength, lightness, thinness and water-urine-exudate resistance to a cast made with new MELMAC BANDAGES.

Davis & Geck

MELMAC®

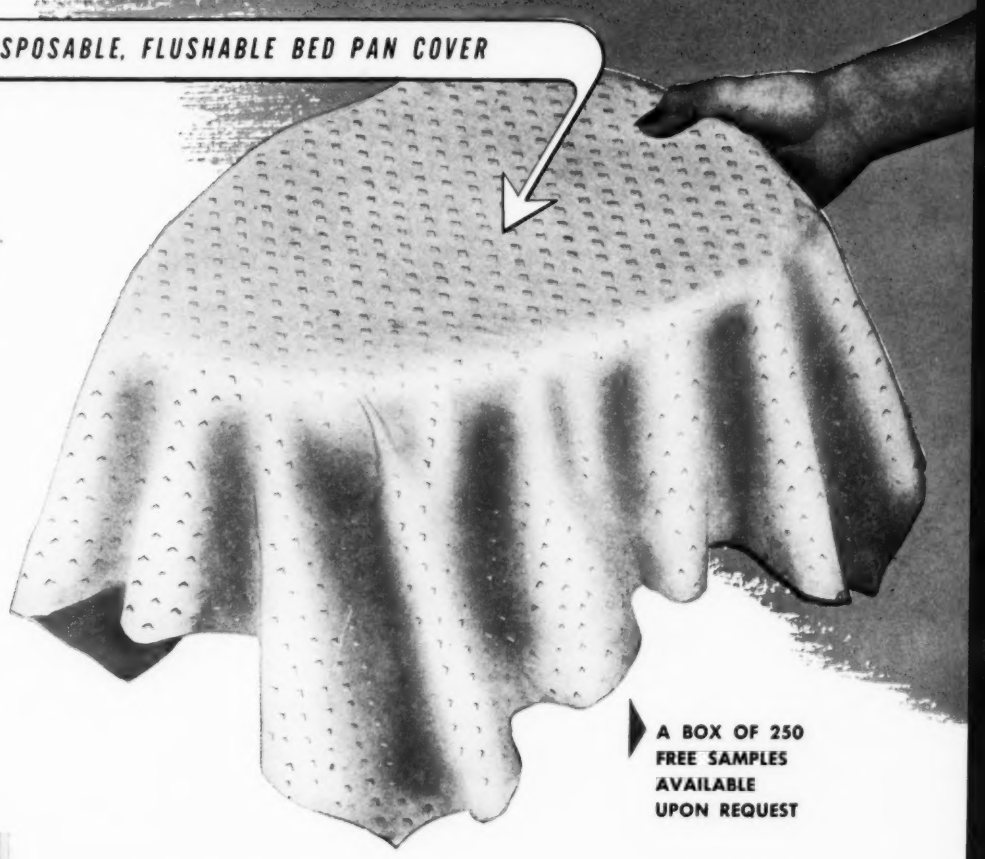
resin plaster of Paris **BANDAGE**

Davis & Geck, Inc., a unit of American Cyanamid Company, Danbury, Connecticut.
Sutures and Surgical Specialties

it's neat...it's economical...it's NEW!

the IPCO PAN-DRAPE

DISPOSABLE, FLUSHABLE BED PAN COVER



another IPCO first!

Requires no new techniques.

• • •

Drapes pan completely.

• • •

Flushes instantly.

• • •

Makes an essential nursing task more agreeable.

• • •

Eliminates costly cloth covers.

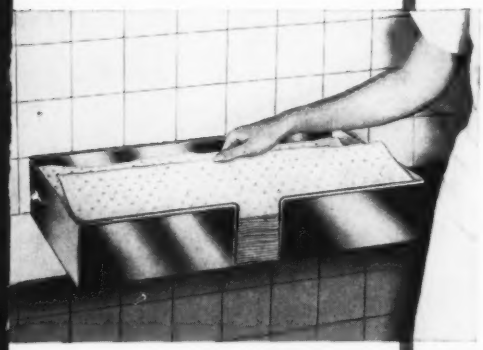
• • •

Eases laundry burden.

• • •

Costs less than one cent each.

A BOX OF 250 FREE SAMPLES AVAILABLE UPON REQUEST



Stainless steel container designed to hold a generous supply of the IPCO *PAN-DRAPE* bed pan covers. Container sets on shelf or can be easily mounted on tile wall.

Inquire About Our Free Offer of These Containers

A specially embossed cellulose material that drapes and clings to pan like cloth

Key hospitals everywhere are enthusiastic in their praise of the IPCO *PAN-DRAPE* —today's most welcome improvement in nursing efficiency. Here is the ideal replacement for makeshift yet costly cover cloths that require constant laundering. The IPCO *PAN-DRAPE* handles easily, quickly, quietly—its high degree of absorbency assures safe, instant flushability within the bed pan washer-sterilizer.

INSTITUTIONAL PRODUCTS CORP.

161 SIXTH AVENUE • NEW YORK 13, N.Y.

WHAT WAS THE

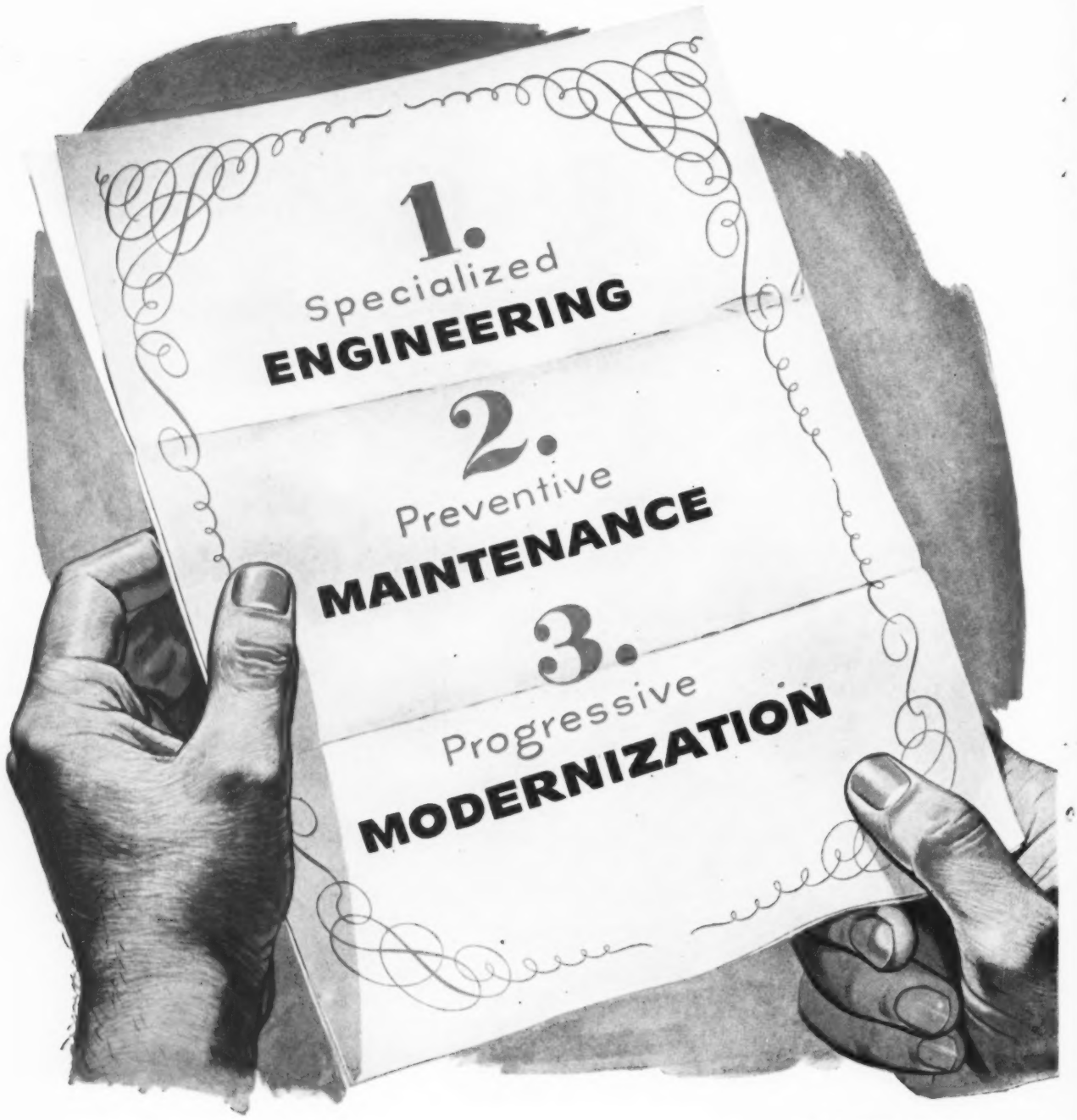
BIG IDEA

For thousands of years, people just put up with rugged transportation. They walked, got blisters on their feet. Built sleds, got aches and pains, until one day some blistered, aching prehistoric genius got fed up and made himself a round affair that rolled. Another big idea was born — the wheel! (P.S. Naturally, the inventor became the world's first big wheel himself!)

MACGREGOR INSTRUMENT COMPANY NEEDHAM, MASSACHUSETTS

Always-On-Duty

OTIS GENERAL DUTY FREIGHT ELEVATORS

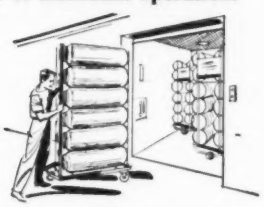


"INSURANCE"

HAVE THREE EXTRA FACTORS OF SAFETY

Whenever you need a freight elevator, it should be on duty. It's like a watch. If it isn't running it's useless. And costly. Especially when lack of elevator service holds up a production or materials handling line, or warehouse delivery trucks, or automobile parking, or mining, etc.

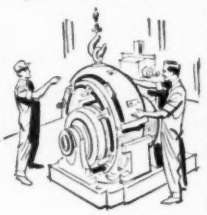
You can save money in the long run with Otis general duty freight elevators. They're standardized. They have lifting capacities of 2,500 up to 10,000 lbs. or more. And full safety features, power doors, self-service or attendant operation.



Only Otis freight elevators can offer you always-on-duty "insurance." It's based upon these 3 extra factors of safety.

1 Specialized ENGINEERING

Otis hoisting machines, which are the heart of the installation, are not adaptations of standard commercial equipment. Like every other part of an Otis installation, they're specifically designed to meet the unique requirements of elevator service. And every part is built in Otis plants under rigid quality control. All with a basic knowledge of elevatoring that can't be matched.



2 Preventive MAINTENANCE

Otis maintenance keeps Otis freight elevators performing like new—*year after year!* Otis service is *engineered-service by the maker* that prevents slowdowns and breakdowns; extends elevator life by 50%; eliminates expensive, unexpected repair bills; keeps replacement parts available over 60 years; supplies field-trained men having an aggregate of 21,500 years' elevator experience; provides 24-hour-a-day service on a nationwide basis through 268 offices. All, because we never lose interest in the performance of an Otis installation.

3 Progressive MODERNIZATION

An Otis freight elevator need never become obsolete. New developments are made applicable to existing installations. We strongly recommend planned, progressive modernization as always-on-duty "insurance."

AUTOMATION

You can have freight elevators where you want them, when you want them. The same advanced electronic skill *that developed AUTOTRONIC® completely automatic operatorless elevators for busy office buildings* is ready to make completely automatic freight elevators an integral part of your production line.

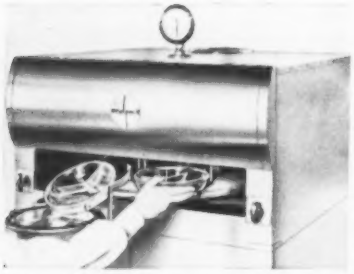
* * *

Our broad experience in the field of industrial elevatoring qualifies us to advise on standard or special adaptations of Otis elevators for unusual freight handling requirements. This experience is available for any size installation, however large—or small. Call any of our 268 offices for details.

Otis Elevator Company
260 11th Ave., New York 1, N. Y.

FREIGHT ELEVATORS

HEAVY DUTY · GENERAL DUTY · LIGHT DUTY



Mealpack Infra-red Dish Heaters *uniformly pre-heat and sterilize each Container's Pyrex Insert for dual-duty as a Dish and "heat storage battery."*

Mealpack Tables *centralize Container packing and tray assembly at the main kitchen—up to 500 trays per hour per assembly line—for all general, selective, special diets.*

Mealpack Tray Carts *act as "portable floor pantries." Soups, beverages, ice cream, fresh-made hot toast, etc., are added to each tray just before each patient is to be served.*

All patients enjoy uniformly delicious food because hot foods stay HOT *and cold foods stay* COLD *for hours—even after serving!*

In Good Hands...

• Your foods, Dietary personnel and standards may be tops. But without MEALPACK'S *unmatched vacuum-sealed protection* they struggle against odds beyond their and your control. Unavoidable *serving* delays! Meals interrupted *after* serving because of nursing shortages! Indisposition of patient! Essential but untimely physician's calls! Costly entrees, deteriorated beyond recognition because soup, salad or other appetizer courses were eaten first!

• Serving all hot foods savory HOT, and all cold foods appetizingly COLD for *every* patient—even up to 2 hours after foods leave one main kitchen—is a job *only* MEALPACK can handle. Whether your hospital is 20 beds or thousands—whether they are located in one building or in widely separated units—an efficient MEALPACK SYSTEM can be "custom-engineered" to combat relentless time, distance and serving problems—to end complaints, ill will, food waste, *excessive* costs!

• The "good hands" behind MEALPACK'S survey and recommendations are backed by a decade of highly specialized research and experience in every phase of institutional food service. Moreover, your MEALPACK SYSTEM is backed by expert, dependable instruction on its correct use and care *after* installation...to *insure* proper results and dividends from your investment.

• If your institution is aiming at top patient care and happiness at mealtime, give your Dietary Department *functional tools* for its big job! Tell your Architect, Consultant or favorite kitchen equipment source you can't afford to settle for less than MEALPACK'S unique vacuum-sealed protection—and savings!

See MEALPACK at A. H. A.'s Annual Convention, Navy Pier, Chicago, September 13-16, 1954. Booth No. 353.

MEALPACK CORPORATION · 2014 RIDGE AVENUE · EVANSTON, ILLINOIS

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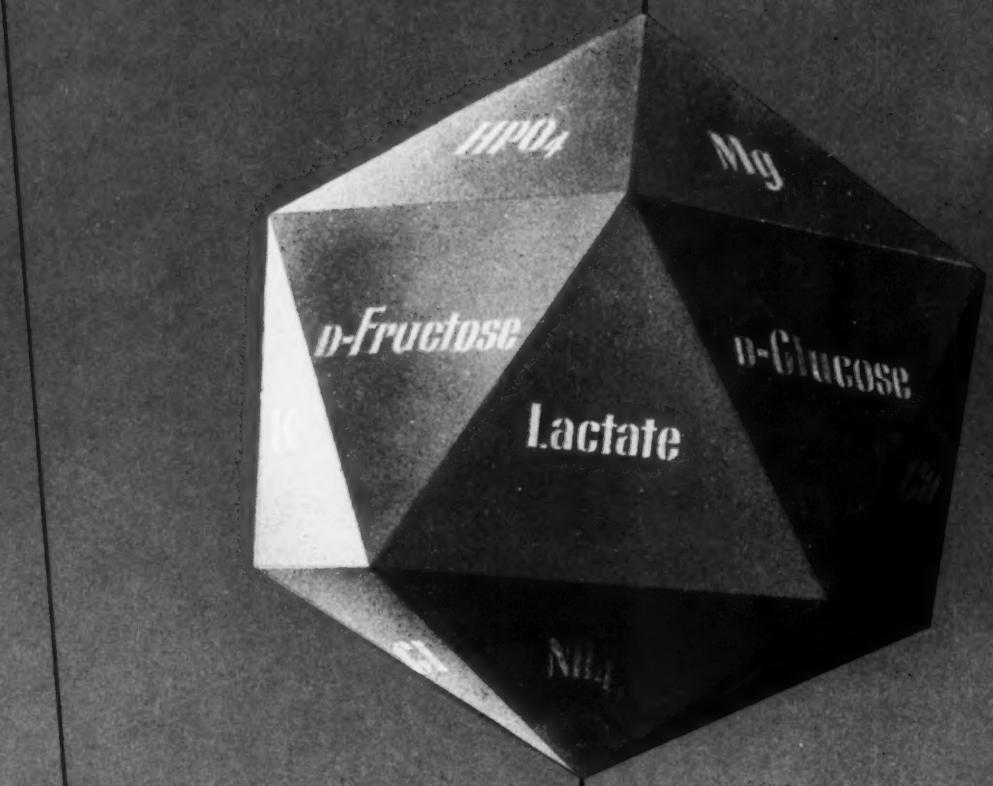


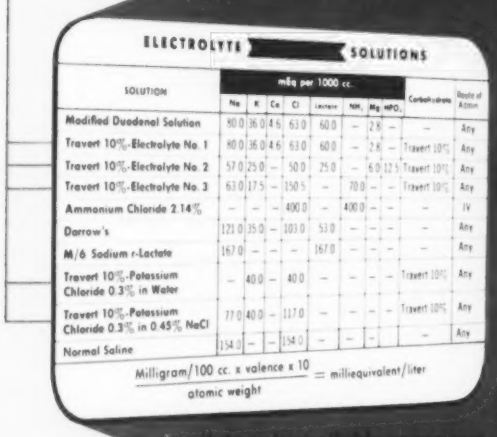
FOR A **Balanced Program**

5 new ***Travert.10%-Electrolyte*** solutions

For a balanced program of **parenteral nutrition**...

5 new

Travert® *10%-Electrolyte solutions*



ELECTROLYTE SOLUTIONS

SOLUTION	mEq per 1000 cc.							Carbohydrate	Route of Admin.
	Na	K	Ca	Cl	Lactate	NH_4	Mg HPO_4		
Modified Duodenal Solution	80.0	36.0	4.6	63.0	60.0	–	2.8	–	Any
Travert 10%-Electrolyte No. 1	80.0	36.0	4.6	63.0	60.0	–	2.8	– Travert 10%	Any
Travert 10%-Electrolyte No. 2	57.0	25.0	–	50.0	25.0	–	6.0	12.5 Travert 10%	Any
Travert 10%-Electrolyte No. 3	63.0	17.5	–	150.5	–		70.0	– – Travert 10%	Any
Ammonium Chloride 2.14%	–	–	–	400.0	–		400.0	– – –	IV
Darrow's	121.0	35.0	–	103.0	53.0	–	–	– –	Any
M/6 Sodium r-Lactate	167.0	–	–	–	167.0	–	–	– –	Any
Travert 10%-Potassium Chloride 0.3% in Water	–	40.0	–	40.0	–	–	–	– Travert 10%	Any
Travert 10%-Potassium Chloride 0.3% in 0.45% NaCl	77.0	40.0	–	117.0	–	–	–	– Travert 10%	Any
Normal Saline	154.0	–	–	154.0	–	–	–	– –	Any

$$\frac{\text{Milligram/100 cc. x valence x 10}}{\text{atomic weight}} = \text{milliequivalent/liter}$$

Pocket cards available on request

all the advantages of TRAVERT 10%

twice as many calories as 5% dextrose, in equal infusion time, with no increase in fluid volume . . . a greater protein-sparing action as compared to dextrose . . . maintenance of hepatic function

PLUS

replacement of electrolytes, and correction of acidosis and alkalosis

products of

BAXTER LABORATORIES, INC.

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DISTRIBUTED AND AVAILABLE ONLY IN THE 37 STATES EAST OF THE ROCKIES (except in the city of El Paso, Texas) THROUGH

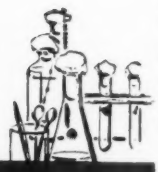
AMERICAN HOSPITAL SUPPLY CORPORATION

SCIENTIFIC PRODUCTS DIVISION

GENERAL OFFICES • EVANSTON, ILLINOIS

a size for every hospital need

From ENT clinic to the OB ward . . .
all departments find CAROLAB COTTON BALLS
are handy and convenient to use—
completely free of nibs and wispy ends.
They are also an economical substitute
for sponges in many hospital procedures.
The laboratory and dispensary
find that they save time and money.
Cleaning instruments and equipment,
stopping test tubes, bottles and capsule containers,
are all duties which can be speeded up
at lower costs with CAROLAB.



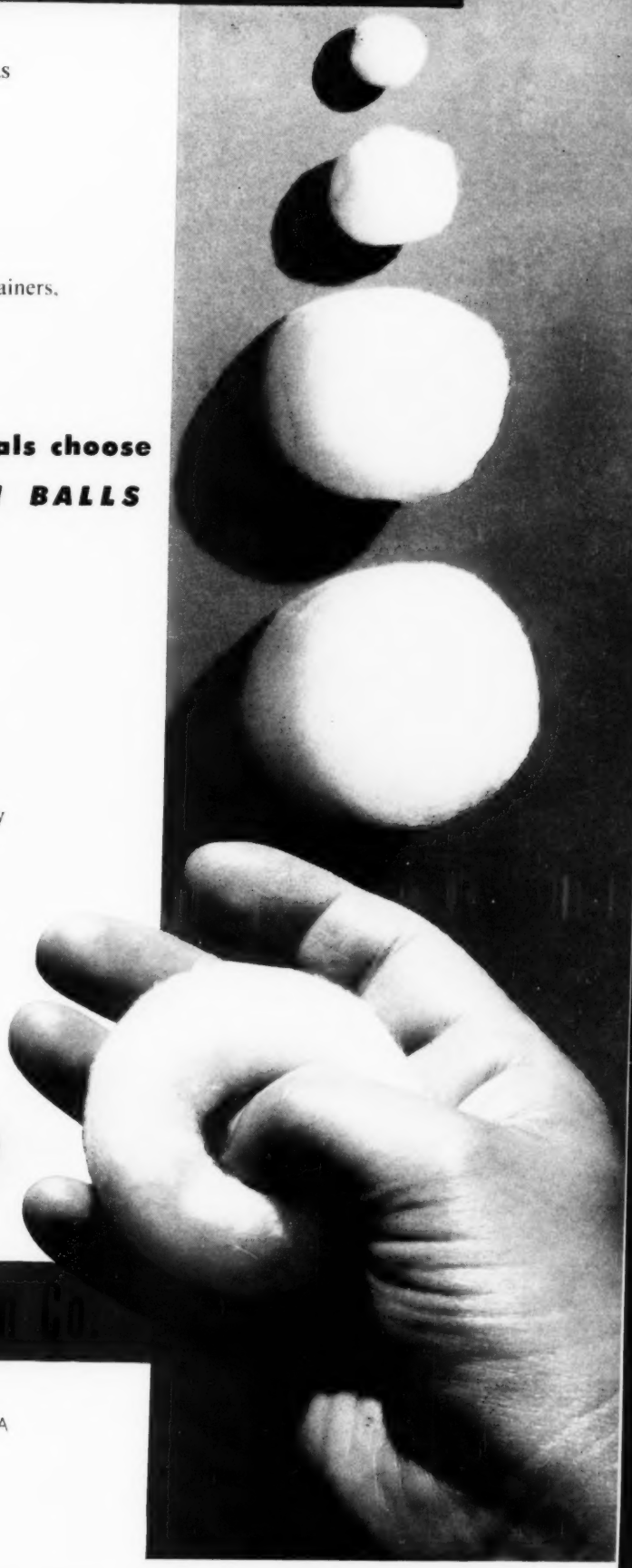
7 reasons why leading hospitals choose CAROLINA COTTON BALLS

1. Uniform in size and shape
2. Firm, compact construction
3. Made of finely spun, selected long staple cotton
4. Highly absorbent
5. Labor-saving—ready for immediate use after sterilization
6. Actually more economical to use than "home-made" cotton balls or other manufactured balls of same high quality
7. Available in 5 standard sizes:

super	2000 per case	
special	2000	*special is same size as large*
large	2000	*but is almost twice as dense*
medium	4000	
small	8000	

WRITE FOR SAMPLES, INFORMATION, PRICES

manufactured
where grown...



Carolina Absorbent Cotton Co.

(Division of Barnhardt Mfg. Co., Inc.)
CHARLOTTE 1, NORTH CAROLINA

Carolina your dependable source

for All Hospital Textiles . . .

- BATHMATS
- BASSINET LINERS
  - *pads*
  - *padding*
- BEDSPREADS
- BLANKETS
  - *Bath*
  - *Crib*
  - *Ether*
- CURTAINS
  - *curtain material*
- DRAPERY MATERIAL
- LAUNDRY FELT
- LINEN MARKERS
- MATTRESS COVERS
- PIECE GOODS
  - *white and colored*
- PILLOWS
- PILLOW CASES
- PILLOW COVERS
- SHOWER CURTAINS
- SHEETS
  - *BED*
  - *CRIB*
  - *bleached*
  - *unbleached*
  - *percale*
  - *contour*
- SHEETING
  - *bleached*
  - *unbleached*
  - *jade green*
- TAPE
- TABLE LINENS
  - *tablecloths*
  - *napkins*
  - *tray covers*
- TICKING
- TOWELS
  - *terry*
  - *huck*
  - *absorbent*
  - *kitchen*
  - *name woven*
- TOWELING
- UTILITY FABRICS
  - *drill*
  - *twill*
  - *duck*
- WASH CLOTHS

Whatever your needs—from a wash cloth to a bolt of drapery material—Carolina has it or can get it. **Your textile problems are our business.**

More important, Carolina has in stock a complete selection of grades—from service weights to luxury items, unbleached muslin to percale—to meet your individual requirements, *and your budget!*

A Carolina representative will be glad to show you samples, help you in any possible way.

Send for a complete Carolina catalog if you do not have one readily available—14-page section on textiles included.

IMPORTANT: Carolina carries only *branded* merchandise—your guarantee of dependable uniformity. High tensile strength, long wearing characteristics are inherent in products bearing the maker's own name.

ROLA
spital supplie

Carolina Absorbent Cotton Co.

(Division of Barnhardt Mfg. Co.)

CHARLOTTE 1, NORTH CAROLINA

quality products of cotton since 1900

"We are particularly proud..."

In the three operating rooms of the newly-renovated St. John's Hospital, real clay tile was chosen for both wall and floor surfaces. "It is so easy to clean and keep clean," reports the Operating Room Supervisor.

"We are particularly proud of the floors," she adds. American-Olean is proud, too, because these floors are Conduct-O-Tile. In each of the three new operating rooms, Conduct-O-Tile now eliminates the main cause of static-sparked explosions. No waxing or special treatment is needed to keep it permanently conductive.

TILE SPECIFICATIONS: Operating Room, St. John's Hospital, Salina, Kansas. Color Plate No. 346. Walls: 14 Spring Green. Floor: Caneweave; Jet Conduct-O-Tile and Green Granite.

CONDUCT-O-TILE eliminates main causes of static-sparked explosions. Newly-developed impervious ceramic tile dissipates dangerous charges of static electricity. Permanently conductive; no free carbon to bleed out or track to other areas; stain resistant and fireproof. Send for complete technical data.

American-Olean Tile Co.

Executive Offices: 1043 Kenilworth Ave., Lansdale, Penna.
Factories: Lansdale, Pennsylvania • Olean, New York
Member: Tile Council of America

AMERICAN-OLEAN TILE COMPANY
1043 Kenilworth Ave., Lansdale, Pa.

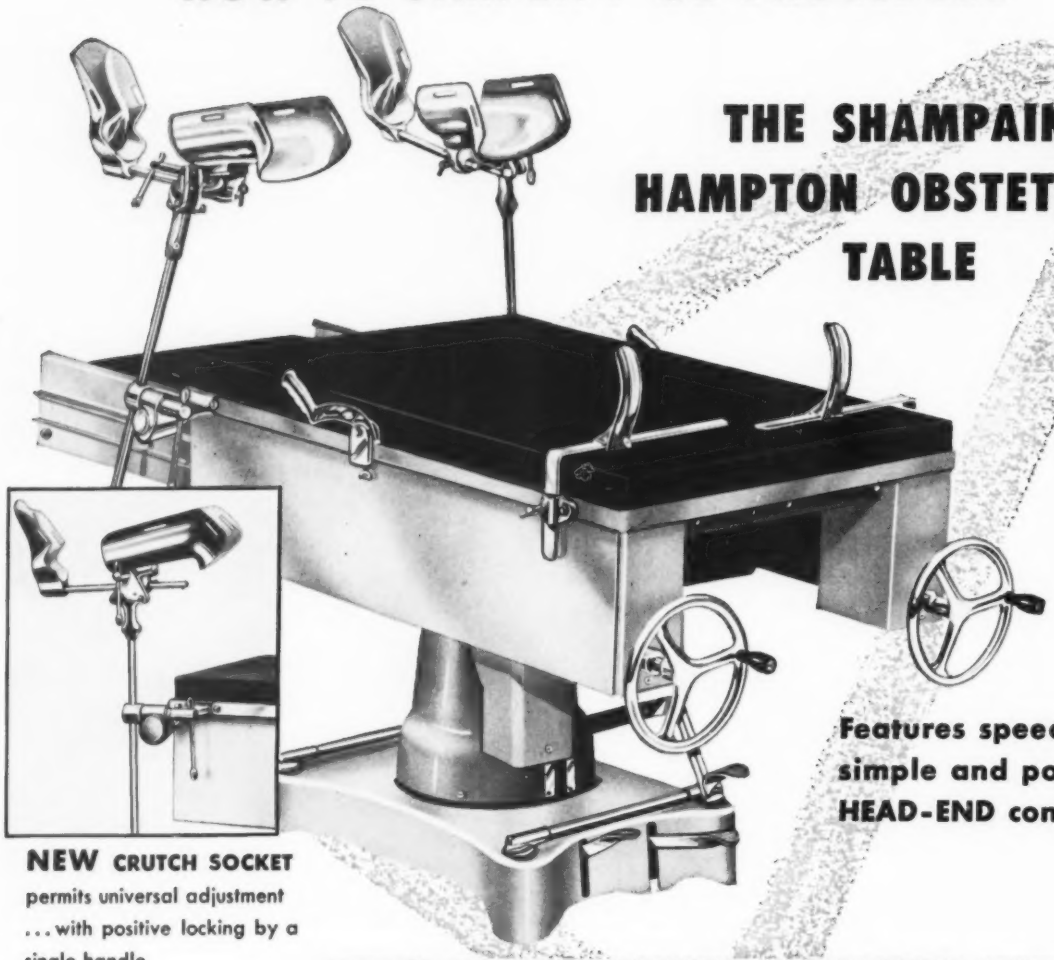
Please send me, without charge,

- ☐ Information and literature concerning CONDUCT-O-TILE
- ☐ Booklet 204, Catalog of Tile Products

Name .....
Organization .....
Street .....
City ..... Zone ..... State .....

HOW TO *SIMPLIFY* OB PROCEDURE

THE SHAMPAINE HAMPTON OBSTETRICAL TABLE



Features speedy, simple and positive HEAD-END controls

NEW CRUTCH SOCKET permits universal adjustment ... with positive locking by a single handle

HERE'S HOW THE SHAMPAINE HAMPTON HELPS *YOU:*

- From labor position to delivery position at the quick turn of a *single wheel.*
- Leg section can be *partially extended* to serve as a shelf.
- Rotation feature of top without moving the base permits "close-up" work.
- Streamlined design permits easy draping.
- Easy to clean because working parts are completely concealed and side and front panels are *stainless steel.*

Shampaine COMPANY

MANUFACTURERS OF A COMPLETE LINE OF PHYSICIANS' AND HOSPITAL EQUIPMENT

See the Shampaine Hampton Table demonstrated at the American Hospital Association Meeting, Booth No. 54.
See also the S-1502 Major Operating Table with new Stainless Steel Base, new Adjustable Height Beds, and Shampaine Operating Room Furniture.

New Faith Hospital helped by American planning

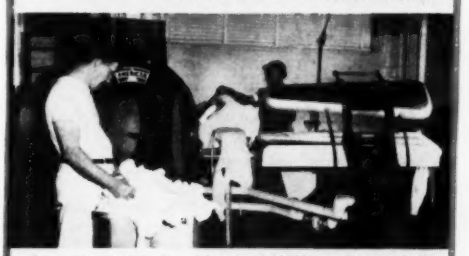
New 56-bed Faith Hospital, St. Louis, Mo., had its clean linen needs surveyed by an American Laundry Consultant. Working with the Architect, American then made the layout for a smooth-operating, efficient laundry. Equipment was specified and installed to keep up a regular flow of work at lowest cost in labor and supplies.

Faith Hospital's American-equipped laundry produces all linens, staff uniforms and other apparel. Quality-laundered linens are returned to service fast. And, better control makes possible a small linen inventory.

Whether you are planning new construction, or want to reduce costs in your present laundry, American can show you the way. There is an American Field Service Office near you, ready to give advice and service at all times.

Cascade Washer and Solid Curb Extractor

2-Roll Streamline Flatwork Ironer



Zone-Air Drying Tumbler and Uniform Press Unit

You can depend on your American Laundry Consultant's advice in your selection of equipment from the *complete American Line*. Backed by our 86 years experience in planning and equipping laundries, he can help solve your clean linen problems. Ask for his specialized assistance anytime . . . no obligation.

World's Largest, Most Complete Line of Laundry and Dry Cleaning Equipment

American

The American Laundry Machinery Company • Cincinnati 12, Ohio

ALM-190

The American Laundry Machinery Co.
Cincinnati 12, Ohio

☐ Send information on Hospital Laundry Equipment.

☐ Have American Laundry Consultant call.

Name_____

Hospital_____

Address_____

City_____ State_____

STERILE SUPPLY ROOM in the new St. Francis Hospital, at Lynwood, California. Mr. H. R. Davies, Architect. Repeated rows of open shelving, above drawers and enclosed cabinets, and an unbroken stretch of counter surface covered with a one-piece Formica counter-top, permit this room to service the entire hospital efficiently and economically. All cabinet work is custom-built, of steel, Bonderized and given a durable baked enamel finish, and was installed by St. Charles Manufacturing Company.

SPECIFY *St. Charles* HOSPITAL CASEWORK

It is St. Charles business to translate, literally, into steel your blueprint designs and specifications for hospital cabinetry and casework, without losing a line or an inch of your original intent. Long years of experience, highly skilled personnel, and America's most modern sheet-steel cabinet plant combine to make your complete satisfaction a certainty.

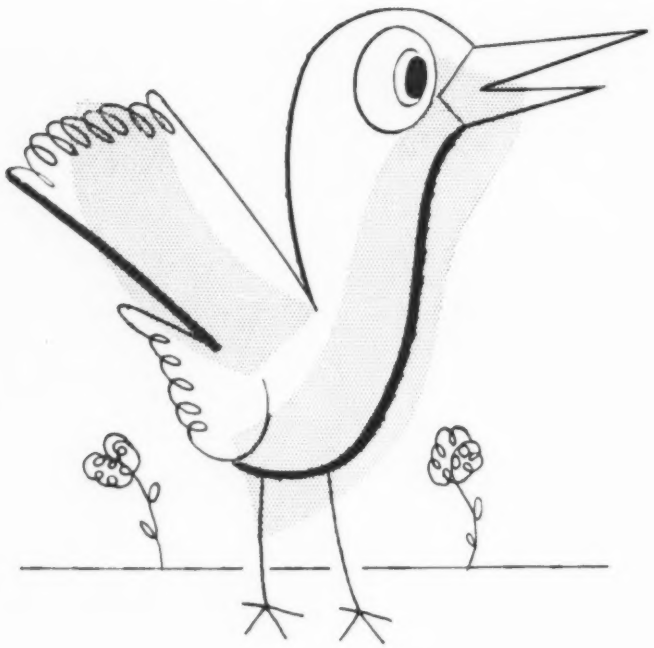
In addition, it is possible that our wide range of special units and accessories can add even more utility to your designs than you had, perhaps, anticipated. This might well apply, also, to our facilities for fabricating long lengths and irregular shapes of seamless, one-piece counter tops, of various materials, bonded onto steel cores.

Your inquiry will bring complete details regarding our service, together with whatever degree of assistance you might wish in original layout and design.

St. Charles

casework • sinks and counters • special purpose units

ST. CHARLES MANUFACTURING COMPANY, DEPT. MH, ST. CHARLES, ILLINOIS



HARD WATER IS FOR THE BIRDS

Maybe birds and flowers like hard water—but we doubt it. Most people don't. Especially those who use large quantities of water, as needed for laundering, boilers, hot water heaters and general services, where ordinary water just won't do.

And that's where Elgin-Refinite comes in. Water softening and conditioning is our business. We have been at it for nearly a half century during which we have come up with some of the most important developments in the field.

For example, our water softener of "Double-Check" design makes possible a deeper zeolite bed which increases soft water output as much as 44% —yet it costs so little more. The ingenious "double-check" arrangement also prevents costly loss of zeolite (this arrangement can be easily installed in your present water softener).

High capacity Elgin zeolites give 3 to 10 times more capacity of soft water output per regeneration. And then there is the outstanding Elgin Ultramatic Water Softener—today's finest fully automatic water softening equipment. Its automatic control mechanism is readily adaptable to any existing water softener.

Yes, if you require soft water in large or small quantities, call on Elgin-Refinite for the most advanced, dollar saving equipment your money can buy.

Elgin-Refinite • *Division of Elgin Softener Corporation*
144 N. Grove Ave., Elgin, Illinois

Representatives in Principal Cities • In Canada: G. F. Sterne & Sons, Brantford

Elgin
REFINITE
SINCE 1908

Water Conditioning since 1908

Compare Water Softeners before you buy

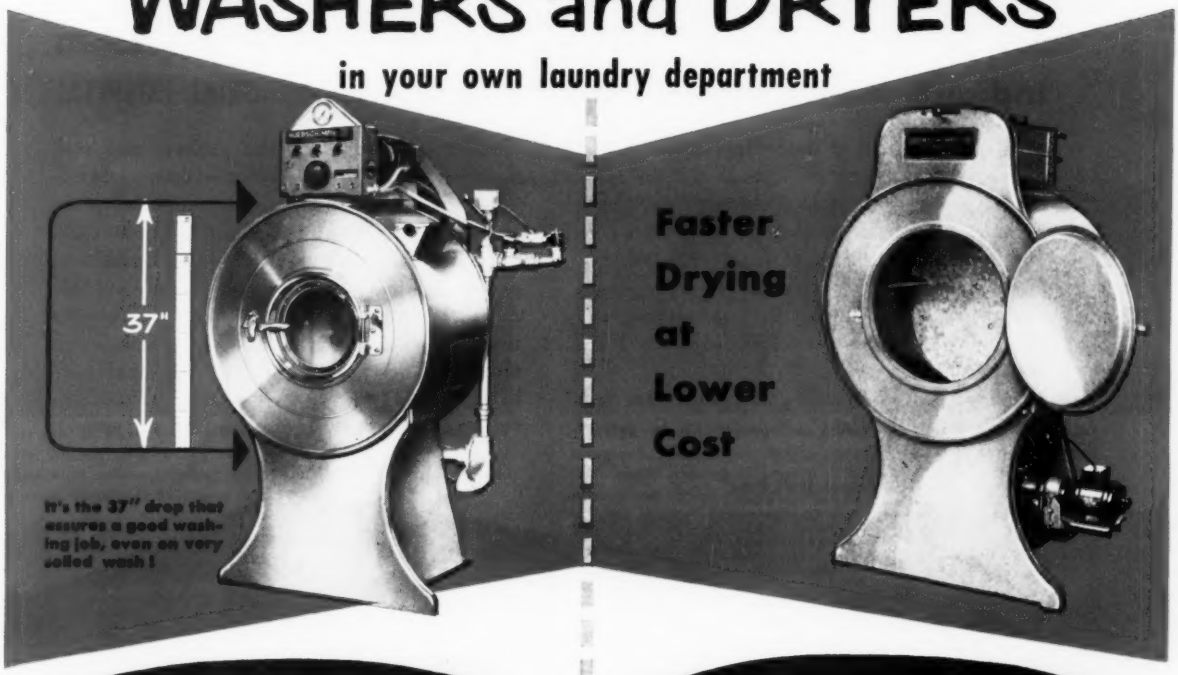
Size for size, note far greater water softening capacity of the Elgin Water Softener.

WHY IT WILL PAY YOU TO CHOOSE

HUEBSCH

WASHERS and DRYERS

in your own laundry department



First for Washing

50 POUNDS CAPACITY • STAINLESS STEEL
MODERN • EFFICIENT • ECONOMICAL
EASY OPERATION • TROUBLE-FREE DESIGN
CHOICE OF AUTOMATIC, SEMI-AUTOMATIC OR MANUAL CONTROLS

Professional laundry owners report the Huebsch washer is ideal for handling small and medium sized loads. Because of its 37" drop and excellent mechanical action, the Huebsch washer does an exceptionally good washing job, even on very soiled wash. Its low first cost and low operating costs have made it a favorite with leading laundry owners throughout the country.

The Huebsch washer is simple to operate, ruggedly built for years of economical, trouble-free service.

First for Drying

All over the nation, leading launderers and drycleaners are drying clothes with a total of more than 100,000 Huebsch dryers invented by Huebsch Originators. This amazing acceptance has been made possible because Huebsch tumblers deliver more satisfaction, more efficiency, more economy than any other tumbler on the market. When you compare Huebsch advantages, you too will choose Huebsch. You get faster drying at lower cost, low initial cost, low maintenance cost, low steam-electric consumption, simplified operation which makes it easier and faster to load and unload.

Four sizes . . . steam or gas heated . . . in both laundry and drycleaning models.

Ask your Huebsch representative for complete details or write us direct.

HUEBSCH Originators

INVENTOR AND WORLD'S LARGEST MANUFACTURER OF OPEN-END DRYING TUMBLERS
Makers of the famous Huebsch Handkerchief Ironer and Fluffer • Pants Shaper • Automatic Valves • Feather Renovator • Double Sleever • Collar Shaper and Ironer • Garment Bagger • Cabinet and Garment Dryers • Washometer • Open-End Washer

HUEBSCH MANUFACTURING COMPANY, 3775 N. HOLTON ST., MILWAUKEE 1, WIS.
Division of THE AMERICAN LAUNDRY MACHINERY CO.

BARBER COLMAN

"UNI-FLO" ENGINEERED

Air Distribution

. . . provides comfort for mental patients at mammoth Indiana institution . . . DR. NORMAN BEATTY MEMORIAL HOSPITAL

Nearing completion at Westville, Indiana, is one of the world's largest institutions for the mentally ill. Since 1949 most of the thirty-four large buildings, plus staff residences, have been constructed at a total cost of nearly $25,000,000. The institution contains a small city within itself with provision for housing, feeding, working, and recreational facilities for 3,250 patients and 450 employed personnel.

Air distribution in most of the project has been engineered with Uni-Flo equipment to assure comfort conditions for the patients and staff members. Uni-Flo Diffusers discourage tampering by inmates as the frames are attached to the walls or ducts by screws in the inside skirt. Cores are then attached to the frames with tamperproof screws. Moreover, patients are not able to stuff paper, rags, pencils, or other objects through the cores to reduce distribution efficiency. Over 2,500 pieces of Uni-Flo equipment have been specified or installed in various buildings throughout this outstanding institutional project.

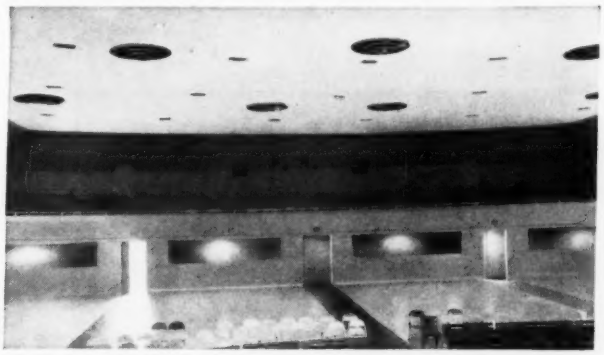
Architects, Engineers, Interior Designers: Boyd E. Phelps, Inc., Michigan City. *General Contractors:* Tonn & Blank, Michigan City; E. H. Marhoefer, Jr. Co., Permanent Construction Company, and Gordon & Company, Chicago. *Ventilating Contractors:* Troeger Sheet Metal and Zack Incorporated, South Bend; Industrial Sheet Metal, Hammond; Reliable Sheet Metal, Chicago.

Auditorium seats 1,400 people, is used for entertainment programs and musical therapy. Contemporary design of facade typifies modern, functional architectural treatment used throughout the new institution.

Disturbed Unit houses violently insane patients. Uni-Flo Sidewall Diffusers in soffit distribute air quietly and uniformly. Each Diffuser is furnished with tamperproof screws.

Aged and Infirm Unit has dining area handling eighty patients at one time. Facilities are available for serving eight hundred patients in various units simultaneously. Uni-Flo Diffusers are installed high on the walls.

Lounge in personnel building measures 50 x 80'. Venturi-Flo Round Ceiling Diffusers unobtrusively supplement over-all modern effect of window walls, recessed lighting, acoustical ceilings, floor, and column treatments. Exterior of building is shown below.

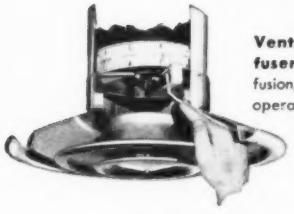


Spacious Auditorium has every modern facility for musical therapy treatments, plus entertainment of patients. Venturi-Flo Ceiling Diffusers (individually adjustable) provide a healthful, comfortable, draft-free atmosphere, without distracting air noise.

Personnel Building houses most of the 450 people on the staff. Facilities are provided here for a kitchen, dining hall, recreation, apartments, private rooms, etc. Equipped throughout with Uni-Flo.

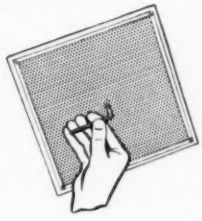
Recreation Room in Personnel Building provides cheerful off-hour surroundings for staff members. Uni-Flo Sidewall Diffusers can barely be distinguished in paneled wall. Note Return Grille in corridor.

Barber-Colman Air Distribution Products as used at Beatty



Venturi-Flo Ceiling Diffusers provide efficient diffusion, rigid construction, quiet operation, easily adjustable deflection and volume control in units noted for attractive, modern styling.

Double Deflection "MA" Sidewall Diffusers have integral volume control, easily removed cores, rapid diffusion, low noise level, and are provided with tamperproof screws.



Uni-Flo Square Ceiling Diffusers are designed for surface mounting on conventional plaster ceiling. Adjustable deflection and volume control.

BARBER COLMAN

"UNI-FLO" ENGINEERED

Air Distribution

BARBER-COLMAN COMPANY • ROCKFORD, ILLINOIS

Air Distribution Products • Automatic Controls • Industrial Instruments
Aircraft Controls • Small Motors • Overdoors and Operators • Molded Products • Metal Cutting Tools • Machine Tools • Textile Machinery

BARBER-COLMAN COMPANY, ROCKFORD, ILL., U.S.A.
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☐ Please send new data bulletin on engineered air distribution equipment, F.4471-2.

Name_____

Firm Name_____

Address_____

City_____ State_____

Aid patient recovery with the new Honeywell Round!

NOW–A NEW THERMOSTAT SYSTEM

In room 204, this patient is well on her way to recovery from minor surgery. Her doctor felt that a temperature of 75° would contribute most to her sense of well-being. This is easily possible because of the Honeywell Hospital Thermostat installed right in her room.

In room 304, the patient suffered extensive skin burns, and his physician prescribed a room temperature of 67° to accelerate heat loss from the unaffected skin areas. This medical practice of prescribing temperatures is possible only with a thermostat in every room.

Individual Room Temperature Control now possible . . . room by room . . . to fit your budget

HERE's a *simple* new thermostat system—the Honeywell Round—that can be installed in your present hospital for as little as $350.00 for 4 rooms.

Start *right away* with the Honeywell Round—have it installed in any heating "trouble spots" you may have. Then, as your budget permits, you can have it installed room by room throughout your hospital.

Installation of the Round is *easy* . . . you don't have to tear up floors or walls . . . *you don't even have to redecorate.* Tiny, simple wiring is used with a Honeywell automatic radiator valve and a miniature transformer.

Today physicians and surgeons in many modern hospitals prescribe *exactly correct* room temperatures to help speed patient recovery. But this medical practice is possible *only with a thermostat in every room.*

This is the only method that can compensate for the varying effects of wind, sun, open windows, and other temperature factors in each room.

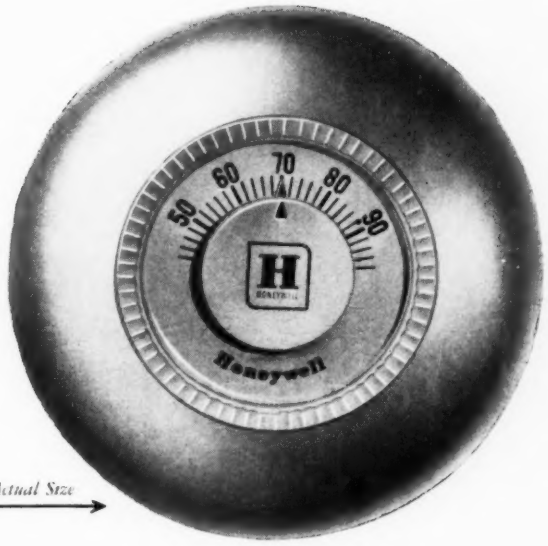
This Honeywell Round System is especially designed for existing hospitals. But whether you're modernizing your hospital or building a new one, Honeywell has the Hospital Thermostat System to suit your particular needs.

Just call your local Honeywell office for complete information. Or, write to Honeywell, Dept. MH-9-158, 351 East Ohio Street, Chicago 11, Illinois. Ask too for your copy of the new booklet "Does this happen in your hospital?"

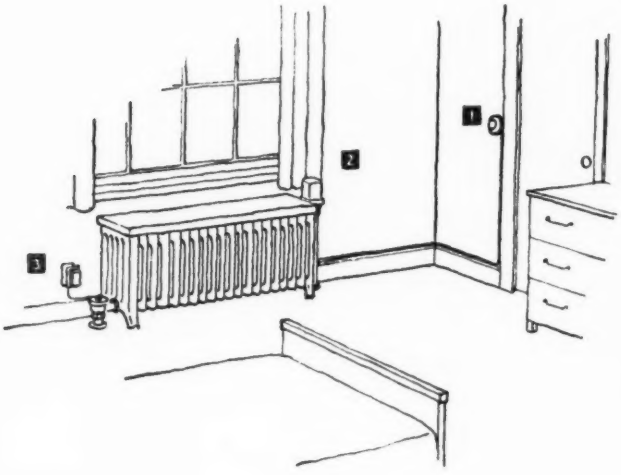
LOW-COST ROOM FOR EXISTING HOSPITALS

The new Honeywell Round features . . .

- **An easy-to-read dial.**
- **Economical installation—*no* redecorating necessary.**
- **Tamper-proof protection—settings and cover can be locked in place.**
- **Sealed, lint-proof mechanism—insures maintenance-free, dependable operation.**
- **Smart appearance—cover can be painted to blend with any color scheme.**
- **Versatility—can be used with *any* type heating system or window type cooling unit.**



Actual Size



The sketch at left shows how easily the Honeywell Round System can be installed in individual rooms in *your* hospital. The attractive thermostat **(1)** blends with the wall . . . it's connected to a Honeywell automatic radiator valve **(2)** and a miniature transformer **(3)** by a tiny wire. It's just as simple and economical as it sounds!

MINNEAPOLIS
Honeywell

Hospital Temperature Controls

112 OFFICES ACROSS THE NATION

TWO GREAT NAMES...

GARLAND
THE GREATEST NAME IN COOKING

AND YOUR

EQUIPMENT DEALER

September 20 to 25th is "VISIT YOUR DEALER WEEK"

The battery formation illustrated includes: Spectro-Heat Hot Top; Open Top; Unitherm FryTop; Deep Fat Fryer; and Side Fired Broiler. Units available in standard black-Japan or Stainless Steel finishes

Garland is proud to pay tribute to the Food Service Equipment Industry and to the Dealers who are responsible for its high standing.

We are happy in the realization that Garland quality and Garland reputation is responsible in part for the fine food service available to the American public.

We know that only by supplying our dealers with a sound, saleable, quality-built product will they prosper. This has been our aim and *accomplishment* in the past, and will continue to be in the future!

One prime product example of this success is this Garland gas-fired battery . . . built for heavy-duty cooking. It's efficient, durable, flexible . . . built to last a lifetime! Just one of many Garland units available for any size commercial cooking operation. That's the reason Garland gas-fired equipment is used in more leading hotels, restaurants, clubs, schools, and institutions than any other make!

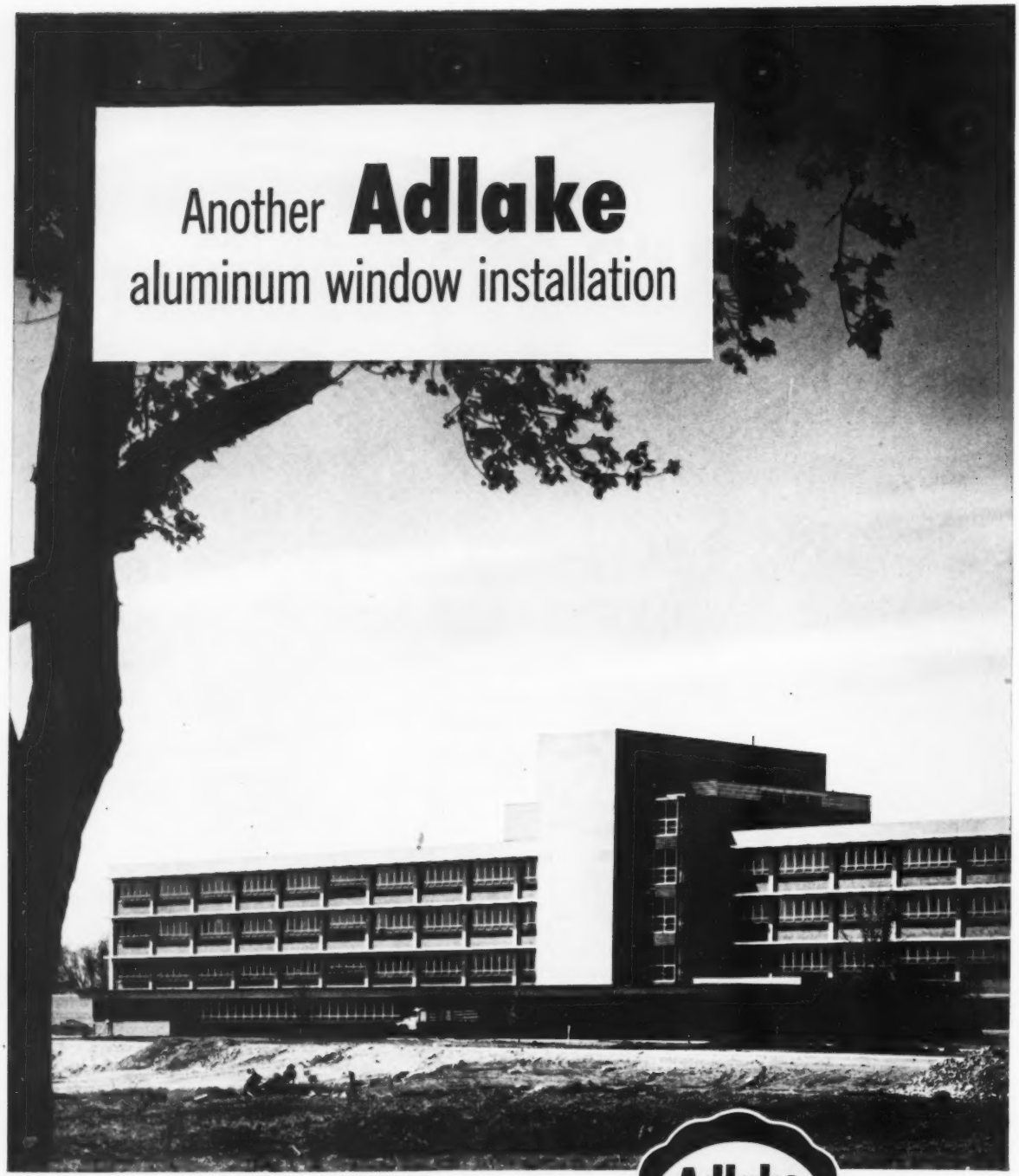
Look for the 45-29 Club pin . . . it's the mark of an expert!

GARLAND

DM PRODUCTS

Heavy Duty Ranges • Restaurant Ranges • Broiler-Roasters • Deep Fat Fryers
Broiler-Griddles • Roasting Ovens • Griddles • Counter Griddles • Dinette Ranges

PRODUCTS OF DETROIT-MICHIGAN STOVE CO., DETROIT 31, MICHIGAN
IN CANADA: GARLAND-BLODGETT LTD.—1272 Castlefield Ave., Toronto



Rockford Memorial Hospital, Rockford, Illinois. Hubbard & Highland; Perkins & Will—Architects. Security Building Company, General Contractors.

- **Minimum air infiltration**
- **Finger-tip control**
- **No painting or maintenance**
- **No warp, rot, rattle, stick or swell**
- **Wool woven-pile weather stripping and exclusive patented serrated guides**

Adlake
PROVEN QUALITY WINDOW

This window meets or exceeds all quality industry specifications for aluminum windows.
THE Adams & Westlake COMPANY

97th year of serving the transportation and building industries

The Adams & Westlake Company

Established 1857 • ELKHART, INDIANA • Chicago • New York

Small Hospital Questions

Cleaning Corrugated Runners

Question: We have recently installed a corrugated rubber runner on our stairways and landings. We have been having a difficult time in keeping this runner clean. We would appreciate any information you might be able to give us in regard to products or methods which may be used for this purpose.—M.D.W., Calif.

ANSWER: The corrugated types of rubber mats usually have the corrugations set at slanted angles which adds to their safety but makes them more difficult to clean. They require precise sweepings in the corrugations and a frequent (perhaps daily) washing with a fine abrasive, followed by enough rinsing to remove every trace of the washing compound. A coat of wax will protect the mats against soil.

The so-called "personalized" rubber mats have both perforated and corrugated sections, with a plain rubber center in which the institution's name or crest is placed. Unless this type of mat is kept very clean its advertising value will be lost. The small perforations fill up with foot soil and debris very rapidly; therefore, they require constant cleaning, especially during bad weather.

Sweeping must include cleaning out the perforations and corrugations. Washing must be so well performed that the mats always look like new. It is usually necessary to use a brush for washing them, with a small amount of fine abrasive, followed by thorough rinsing, and, if desired, a film of nonskid wax.

Don't Divulge Prices

Question: I often hear discussed the question of whether or not any company's quoted prices should be made known by the purchasing agent or administrator to another company. Please let us have your opinion on this. If in your opinion it is not ethical to disclose such quotations, why wouldn't it be all right to make known to everyone what prices were quoted without disclosing the name of the company who made the quotation?—E.S., Minn.

ANSWER: Many federal, state and local governmental hospitals must by law publish all bids received when bids are sought on any commodity to be purchased. Of course, where the law specifies it, it is quite all right and in fact necessary. However, it has always been held by most capable purchasing agents that, wherever the law does not demand the disclosure of quoted prices, all such quotations are a privileged communication between the quoter and the buyer and should never be divulged. Certainly it is not fair to the company that made the low bid initially to reveal the bid to another company and thus enable it to submit a lower figure in an attempt to get the business. If it resorts to such unfair practices, a hospital will soon find it most difficult to get anyone to bid on its requirements.—E. W. JONES.

How to Define "Emergency"

Question: We have an arrangement with a county authority providing for service rendered "in case of emergency," but there is no precise definition of what constitutes an emergency. Recently a question has been raised on this point. Is there any standard definition of the term "emergency" in the medical usage?—J.D.K., Ohio.

ANSWER: For purposes of determining staff appointments and organization, the Joint Commission on Accreditation of Hospitals has defined an emergency as follows: "An emergency is defined as a condition in which the life of the patient is in immediate danger and in which any delay in administering treatment would increase the danger."

In general usage, the term certainly applies also to situations in which there is no actual threat or hazard to life, but where delay in administering treatment may cause suffering or possible complications.

Keeping TB Patients' Records

Question: Will you let us know the length of time clinical laboratory and other hospital records on tuberculosis patients must be kept in our files, for legal purposes? We should also like to know the length of time we should keep chest x-ray films of tuberculosis patients.—R.E., N.J.

ANSWER: It is doubtful that there is any uniform procedure throughout the country for the disposal of laboratory records and films of tuberculosis patients. In some cases, state laws may govern the disposal of such records. Accepted practice provides for the disposal of negative x-ray films after six months; positive films are retained for five years, or longer if the patients are still under medical supervision.

For other than tuberculosis patients, the length of time records should be retained depends on the nature of the record, the type of case, and the research or teaching needs of the medical staff. These factors have all been extensively reviewed in the hospital literature.

Problem in Accreditation

Question: For a very small hospital with a small medical staff, is it possible to combine some of the committee functions required by the Joint Commission on Accreditation of Hospitals, so that the same staff members do not have to meet repeatedly to perform their duties as members of the different committees?—A.R., Fla.

ANSWER: For the staff consisting of only 10 or so active physicians, it is permissible to organize a "committee of the whole," which may then perform the separate functions of the executive, credentials, joint conference, records and tissue committees, which are essential for approval by the commission. Another combination of committee functions that is possible is the organization of an "audit committee" to replace the records and tissue committees, performing the stated functions of those two groups.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

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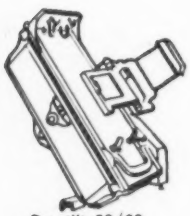

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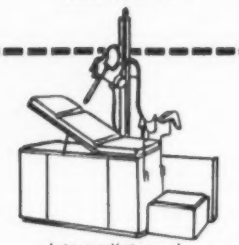
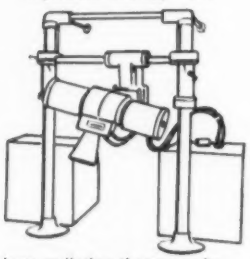
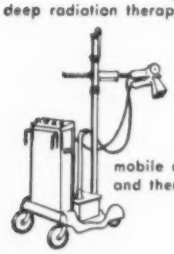


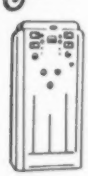
intermediate and superficial therapy units



deep radiation therapy units



mobile diagnostic and therapy units



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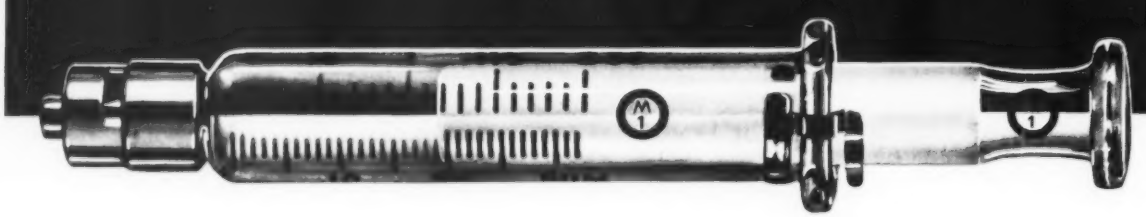

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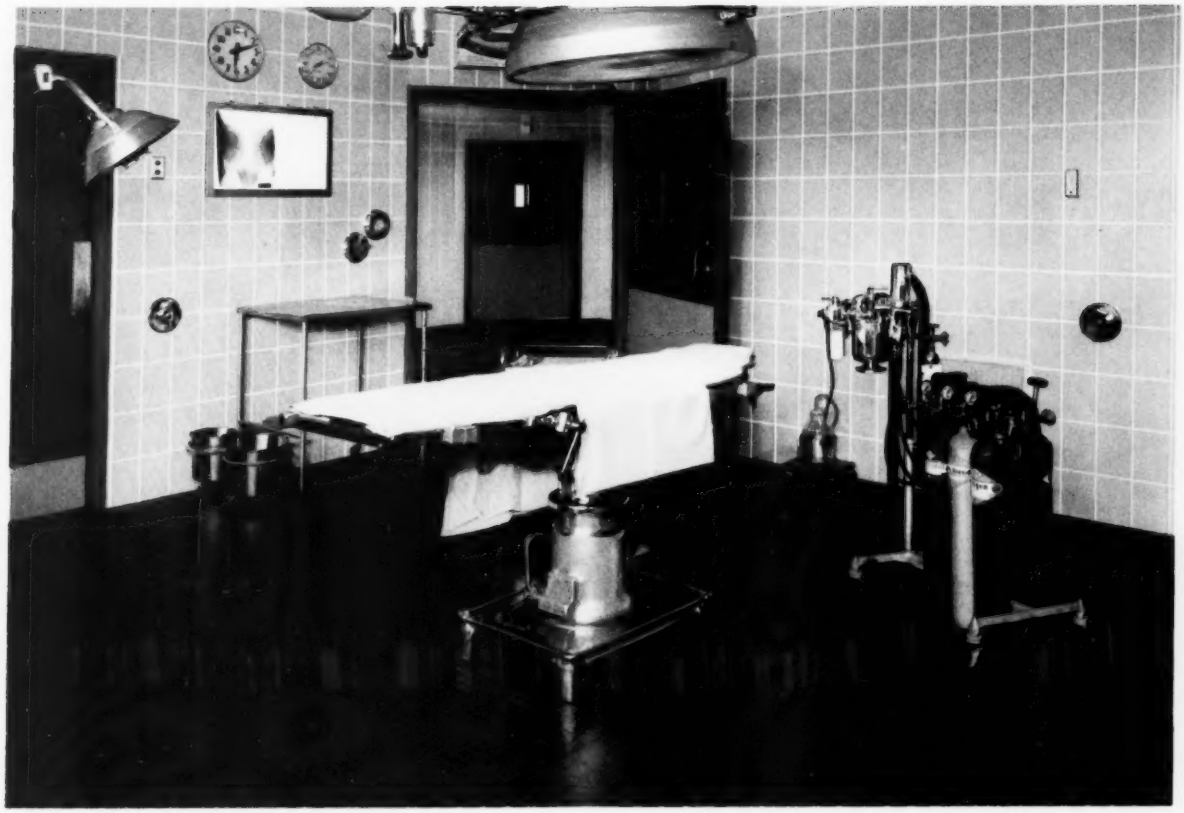

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DOCTOR DRAFT

Young hospital interns and residents in Priorities 1 and 2 of the doctor draft act who have delayed application for commissions are causing Selective Service and the armed forces a long series of headaches. It was expected that when their residencies or internships concluded in the spring they would be all ready for military service, their commissions in their pockets.

Instead a high percentage of these young physicians, many of whom are obligated under the regular draft as well as the doctor draft, just sat tight and did not apply. The result was that when summer came there weren't enough men, commissioned and ready and waiting for a call, to meet military requirements. An additional complication was the fact that there was some confusion over records, and the authorities could not immediately put their fingers on the most draft-eligible men.

Because of the delays, a number of men up to 31 years of age in Priority 3 had to be called, something the Washington authorities wanted to avoid if possible at this time.

Belatedly, to correct the situation, the National Advisory Committee to Selective Service first pleaded with the men to sign up immediately. At the same time hospital authorities and deans of medical schools were asked to cooperate by supplying names and addresses of this particular group of men, and hospitals were cautioned not to extend their internships or residencies.

Even that didn't produce results fast enough. The next step was to call for the immediate induction under the regular draft (as privates) of men who were in line for induction under the doctor draft but who had not applied for commissions. This latter action is not a threat; if the men who are wanted don't step forward shortly the induction as enlisted men will follow. Once inducted, of course, they will be eligible for commissions, but not for the $100 per month bonus pay.

GOVERNMENT'S RÔLE IN HEALTH

Leading national groups and associations concerned with the health of the public are being asked what they think the federal government's rôle should be in health matters.

The request for their views is coming from a study committee of the Commission on Intergovernmental Relations set up by Congress last year to investigate the complicated relationships between Washington on the one side and the state, county and local governmental units on the other.

Basically, the study committee wants to learn if the federal government is doing enough, if it is doing too much, and whether what it is doing is being handled in the right way. Considering the back-to-the-states philosophy of the Eisenhower Administration, the committee certainly will be anxious to find areas from which the federal government can withdraw part way or all the way.

The questionnaire sent out by the committee covers the whole range of relationships between Washington and the states and cities. Specific questions are asked as to whether the federal government should contribute more or less for particular activities, whether federal controls are obstructive, and whether the federal government, by "spending its way" into state programs, is a threat to states' rights.

Federal grants for hospital construction are the biggest single program with which the committee must deal. Four of the 11 questions are aimed specifically at hospitals. They are:

"Do you believe that the bed ratios of 4.5 per 1000 for general hospitals and 5 per 1000 for mental hospitals and 2 per 1000 for chronic disease patients are realistic standards in terms of recent therapeutic advances?

"Does your organization favor a loan procedure to private nonprofit groups for hospitals on a basis similar to Federal Housing Administration loans rather than outright percentage grants or gifts under conditional administrative provisions as under the Hill-Burton hospital construction program? (This is a reference to the Kaiser-Wolverton bill of the last session, which died in Chairman Wolverton's House committee.)

"Has your organization made any studies which might help to determine whether or not states or local communities possess the fiscal capacity and initiative to carry on health and hospital construction programs to an adequate degree should federal aid in these areas be reduced or discontinued?

"Would your organization be willing to participate (on a free basis) in an appraisal of the fiscal capacity and willingness of states and local communities to carry the entire program cost or a substantially increased cost of hospital construction and health programs?"

The committee has promised to make public the returns from the poll as soon as they can be analyzed. Meanwhile, it is only a reasonable assumption that the commission will not receive many replies saying federal help isn't needed for hospitals. Congress itself has shown no inclination to cut off this federal aid.

Dr. Franklin D. Murphy, chancellor of the University of Kansas and former dean of the Kansas Medical School, is chairman of the study committee.

Organizations not already contacted by the committee directly should communicate with William H. Church, Commission on Intergovernmental Relations, 18th and F streets, N.W., Washington, D.C., if they wish to submit views.

A.C.S. STUDY PROGRAM

During the next three years many American hospitals will be hosts to European physicians participating in a study program under the direction of the American College of Surgeons.

The plan is to invite 100 foreign doctors—public health officers, civilian defense experts and specialists of various types—to come to the United States for definite periods of study. Most will be located in hospitals, but some will be assigned to laboratories and other institutions.

A few of the older specialists will limit their visits to a few months, but the bulk of the younger men are expected to stay for assignments of up to three years. The objective is to familiarize the Europeans with the latest American methods of surgery and hospital management.

Under arrangements worked out with the Foreign Operations Administration, the college will maintain a Paris office to cooperate with local committees that will make the actual selections in western European countries. The foreign countries will pay transportation costs, but other expenses will be met from a fund of about half a million dollars allocated by F.O.A. for that purpose.

As a by-product of the program, the F.O.A. noted that Americans traveling in the participating countries in the future may expect better medical care as the result of the European doctors' study here.

PURCHASING GROUPS NOT TAX FREE

Internal Revenue Bureau has ruled that if hospitals or other charitable, nonprofit institutions set up a corporation to do their purchasing, the corporation is not exempt from federal income taxes.

The specific issue was: "Whether a corporation organized and operated for the primary purpose of operating and maintaining a purchasing agency for the benefit of its otherwise unrelated members who are exempt from federal income tax as charitable organizations, is itself exempt under the revenue code. . . ."

The corporation in question received its income from dues, cash discounts on purchases for members and service charges. It realized "substantial" profits but only a portion of the profits were distributed to the hospitals and other institutions that made up the corporation's membership.

The adverse ruling was based on the fact that although the corporation served tax exempt organizations, the corporation was engaged in a business enterprise, and not in a charitable operation. "It is apparent," the bureau said, "that such activities in themselves cannot be termed charitable, but are ordinary business activities."

HEALTH REINSURANCE TO RISE AGAIN

The Eisenhower Administration is determined to resurrect its health reinsurance program and attempt to get it enacted at the next Congress, opening in January.

As Congress adjourned, Secretary Hobby admitted that her department "fared very well" on Capitol Hill. "The only setback was health reinsurance, which was recommitted by the House to the interstate and foreign commerce committee. It was a new and novel idea, and many new and novel ideas don't get by the first time." She added:

"I am not discouraged. Maybe we can write a better bill. Maybe we can be more specific."

Meantime, with the blessing of the White House, Mrs. Hobby's aides are attempting to contact individuals and organizations opposed to reinsurance to see if a bill can't be written that will receive their support.

On his own, Chairman Wolverton of the House interstate and foreign commerce committee has sent out letters to many witnesses who testified at the hearings asking their advice about changing the reinsurance bill or doing something else "to help make it easier for the ordinary people to pay their doctor and hospital bills."

ALLOCATION OF FUNDS TO STATES

The only major defeat of the Administration in the health fields came on the reinsurance bill. Legislation to change the system for allocation of U.S. funds to the states for public health work was tied up in the Senate labor and welfare committee, but the Administration did not make much effort to spring it loose, although it was a part of the Eisenhower program. Mrs. Hobby explained that the delay of a year will allow many of the states to amend their programs to fit in with the proposed federal changes.

In the main the bill would eliminate the various categories, such as venereal disease work, for which the federal dollars are earmarked. It would give the state health commissioners the authority to spend the federal money where they think it will do the most good in their particular states.

It will without question be brought up next session, and there is every likelihood that it will be enacted.

EMPLOYES' HEALTH INSURANCE

One major part of the Administration health program for next Congress—a health insurance plan for federal employes—was introduced in the closing days of the last Congress. Sponsors admitted they had no hope of favorable action until next year. They said it was introduced to stimulate discussion, build up support, and make possible detailed studies of the bill.

The plan is simple. There would be no over-all national health insurance for all federal workers. Instead the pattern would vary with different departments and different geographic areas. The head of each government department would be required to negotiate, with the assistance of employe associations, a number of health insurance contracts to which the employes could subscribe.

The employe would not be required to participate, and if he wanted protection he could make his own choice of the various plans offered—hospitalization, surgery, medical care, comprehensive insurance, or any combination. The federal government would contribute a maximum $26 a year toward the cost—$1 each pay day. The rest would be paid by pay-roll deductions, which the bill would authorize for the first time.

Up to now, while the federal government has been publicly enthusiastic about health insurance, the prohibition against U.S. pay-roll deductions has been the greatest practical obstacle to the growth of insurance among the 2,500,000 U.S. civilian employes.

HILL-BURTON FARES WELL

As anticipated, the regular and expanded Hill-Burton hospital construction programs fared well enough in Congress, despite some worries earlier in the year. The regular appropriation is back to $75,000,000 for the current year. The new program, for the construction of chronic disease hospitals, diagnostic-treatment centers, nursing homes, and rehabilitation facilities, will have an additional $21,000,000, plus $2,000,000 for surveys. It will be allocated as follows: $6,500,000 for diagnostic-treatment centers and the same amount for chronic disease hospitals, and $4,000,000 each for rehabilitation centers and nursing homes. State health commissioners or hospital authorities may reshuffle the funds, except for the vocational rehabilitation money. Also, the interests of mental health programs are protected in states where this operation is supervised by the state health commissioner.

The Modern Hospital
SEPTEMBER 1954

LOOKING AROUND

Hospitals and the Press

IN RECENT years doctors and hospital administrators have spent a considerable amount of their time worrying about what is generally believed to be a bad press or bad public relations. Critical articles about doctors and hospitals have appeared in the nation's magazines and newspapers, and the appearance of every such article becomes the occasion for doctors and hospital people to get together and wonder what is the matter. "What have we done that is wrong?" they ask one another, or "What have we failed to do that we should have done?"

Before we examine these questions here, the sensible thing to do is to determine, first, whether or not it is true that medicine and hospitals are getting a bad press. We shall assume, for the moment, that newspaper and magazine articles which are critical of doctors and hospitals, or put them in an unfavorable light, constitute a bad press, and that articles which glorify the doctor and hospital and put them in a favorable light are a good press. What, then, is the score?

The truth of the matter is that doctors and hospitals get a much better press than most of us believe. Of more than 300 magazine articles listed in the "Reader's Guide to Periodical Literature" on the subjects of hospitals, nursing, medical service and medical practice for the period March 1951 to March 1953, for example, not more than a dozen or so appeared to have any critical or unfavorable aspects whatsoever, and I suspect that if a similar count could be made of all articles dealing with these subjects in the nation's newspapers, a similar proportion would be revealed.

A few months ago, I attended a conference with a group of science writers representing the nation's principal metropolitan daily newspapers, wire services and magazines. They were meeting with a group of leading physicians to discuss some of the ethical problems of hospital and medical practice today. During the course of the discussion, one of the doctors complained about the tendency of the press to sensationalize unethical practices and, as he stated it, magnify the problem out of its true proportions. His statement was immediately challenged by one of the science writers. "All of us here at this meeting," the writer said, "have been filing two or more stories a day all week long —every one of them reporting some new advance of clinical science—a successful new treatment, a new surgical technic, a promising diagnostic method, something that reflects credit on your profession. A few of us will write one story dealing with some of these ethical violations that concern you. Even if these stories are featured by our papers, it seems to me, the balance is still overwhelmingly favorable to medicine." This is pretty much the way it goes the year around.

I'm inclined to agree with this writer that hospitals and the medical profession, on balance, have a good press rather than a bad press. This is still assuming that any article which is critical of hospitals or the medical profession is a bad article. The fact is that this is a poor basis for measurement. A newspaper or magazine article that is critical of hospitals and doctors may be a good article, if it is fair and reasonable in its criticism. It is only when criticism is unfair or unreasonable—when a story is one-sided and biased—that we can justifiably take exception to it. These are the articles, perhaps, that most of us tend to remember when we are brooding about our public relations problems, but, actually, there aren't very many of them, compared to the number that are fair and favorable.

On the other hand, I submit that an article may place hospitals and doctors in a favorable light and still be a bad article. For example, I suppose most of you remember an article in a national magazine a few months ago describing the school of nursing at one of our fine Eastern hospitals. Most of my friends in the hospital and nursing fields hailed this as a constructive article, because it made the nursing profession desirable and pictured the life of a student nurse as a long, wonderful dream. I should like to suggest to you that this was a bad article—as bad in its own way as the articles on fee splitting and unnecessary operations and laxity in hospital nursing service are bad in their way. They are all bad to the extent that they depart from the truth. In the long run, I believe, publicity that departs from the truth on one side is as harmful, though certainly

Condensed from an address by R. M. Cunningham Jr., Western Association of Hospitals, April 1954.

not as painful, as publicity that departs from the truth on the other.

We must consider now what the truth is, and how it can be measured in terms of newspaper and magazine publicity. It is important to remember that truth and fact are not the same thing. An article may be factual throughout and yet depart from the truth by a wide margin, by leaving the impression that a particular set of facts constitutes the whole story. This is the point at issue in connection with the articles that have appeared in national magazines on the subject of surgical fee splitting and unnecessary operations. Some of these articles, unquestionably, have given the impression that unethical practices are the rule rather than the exception in medicine, and have, as charged, thus undermined public confidence in doctors and hospitals. This is bad reporting, because it is untruthful. Other articles on the same subjects, however, have been careful to point out that ethical violations involve a small, though unknown, fraction of the medical profession. This is good reporting; these articles perform the valuable service of telling the public the truth. This is the everlasting obligation of the press in a free society, and we are wrong to oppose it, even when the truth may hurt.

Sometimes, hospitals get hurt in the press through nobody's fault, particularly, but because of the nature of the hospital's business. This was what happened, in part at least, in the case of the Woodlawn Hospital of Chicago last winter. You remember the facts of the case. An infant with severe burns was brought to the hospital, given emergency treatment, and, when it developed that her parents were unable to pay for continued care, transferred to the Cook County Hospital. Assuming for the moment that the medical judgment of the examining physician was correct, nobody was to blame here. Nevertheless, in reporting the case, the newspapers, without deviating from the essential facts, made it appear that the hospital followed a "money first, service last" policy. The baby died a few hours after its admission to Cook County Hospital, and a great uproar followed; most newspaper readers jumped to the conclusion that the hospital's financial policy had been responsible for the baby's death—a view that was unsupported by evidence presented at public hearings conducted by the city's health department, and at the coroner's inquest. This was an unfair conclusion, certainly, and the hospital was unjustifiably injured. The precise cause of the baby's death was never determined, and most professional observers, including a special investigating committee of the Chicago Medical Society, were satisfied that adequate treatment and medical judgment were provided by the Woodlawn Hospital.

Of course, explanations by the hospital, and on behalf of hospitals generally, were buried in the inside pages of the newspapers, while the Woodlawn case, including sensational charges against the hospital by publicity-seeking city and county officials, stayed on page 1. In a well ordered world where justice prevailed, the charge and the reply would be published simultaneously and given equal space. Unhappily, however, the world is not so ordered, and the responsibility of the daily newspaper is to report the news as it happens, and not to administer justice. These are facts of life which are not likely to change, and so you must be prepared to endure and suffer occasionally some unfavorable publicity that does you an essential injustice. When these things happen, I hope you do not forget the many, many times the newspapers publish stories which reflect credit, rather than discredit, on your emergency services. Every time the newspapers report that the victims of an accident were treated at such and such a hospital, for example, you get credit with the newspaper reading public for the protective nature of your community service; painful as it is, the occasional outbreak of a Woodlawn Hospital story does not mean, as many hospital people think, that hospitals never get fair treatment in the newspapers. On the contrary, they usually do.

Nevertheless, it is a fact that in many places, and especially in large cities with competing daily papers, there is a disposition on the part of newspaper reporters and editors to be critical of hospitals. Some of this conflict is inevitable, I suppose, because on certain occasions there is a natural opposition of occupational interests, when it is the newspaper's job to obtain and print information that it is the hospital's job to withhold, in the interest of its patients or its physicians. However, these occasions are not frequent, even in large cities, and the friction resulting from them can be reduced to a minimum when hospital people deal fairly and openly with newspapers, telling all they can tell and explaining the reasons it is necessary sometimes to withhold information. In too many cases, hospitals have held the newspaper reporter at arm's length instead, telling him nothing at all and antagonizing him needlessly.

This still happens. A few weeks ago, I was attending a hospital convention when a shooting occurred in a near-by town. The victims were taken to a suburban hospital whose administrator was away from home, attending the convention. In his absence, no one had been assigned the responsibility of handling inquiries from the press. When reporters from the city papers started calling the hospital, they got an uncommunicative run-around. Yet the same day, and the next day, all the papers had assigned reporters to the convention, where they worked hard trying to dig some news for their readers out of the speeches and discussions. Several of them noted the ironic contrast.

Of course, many hospitals today, especially in cities, have full-time public relations officers whose business it is to provide information for the press. Sometimes, however, these public relations offices are so managed that the press considers them an additional hurdle or obstacle to be gotten over in the quest for information, instead of as an aid to the newspapers and the public. Not long ago, for example, a friend of mine who is an attending surgeon at a large teaching hospital with a newly established public relations office told me about treating an accident victim who was brought to the hospital, then getting a call from a reporter on one of the papers with whom he had dealt on a number of similar occasions and struck up an acquaintanceship. "I can't tell you anything about the case," the surgeon told the reporter when he called. "Under

(*Continued on Page* 132)

A Psychological Study of

THE HOSPITAL-PATIENT RELATIONSHIP

What the Patient Really Wants From the Hospital

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TWO years after her operation she recalled it quietly, in a cultured and soft voice. Her hand went delicately up to straighten a strand of the white hair. And what she spoke of was fear. And of that sudden unexpected rise in her of a child's cry.

"The hospital aide came in that morning and said, 'My, you're a funny one. You know what you were yelling for all night, you were calling for your mother.'" She paused, and looked to the interviewer to see what she thought. Then she began again, more quietly, "Well, I was so upset that I wept. That afternoon they wheeled me out onto the sun porch and even though there were people who came to see me I just wept. It horrified me that still after all these years—I am a woman of fifty years—I was calling for my mother."

She looked at her hands and smiled and shook her head. But as she remembered, she grew serious. She looked again at the interviewer.

"That nurse's aide may have thought it amusing that a gray haired lady of fifty was calling for her mother. But somehow to me it had a different meaning," and then as though thinking of something else, she said, "You know, I was afraid. I didn't think of my children or the family. I just thought of me."

These are the words in the record of a highly educated, mature woman. The depth of her feeling echoed in all the interviews conducted in a pioneering study by the Institute for Research in Mass Motivations into the hospital-patient relation. It highlights the most significant finding in the study.

The study revealed that in every instance the adult patient entering a hospital becomes emotionally a "child." This is reported in the study by the institute. The rather unexpected finding contradicts a large part of prevailing hospital practice, which still deals with the adult patient as primarily an adult.

In light of the number of new insights achieved by the study into the patient's very special emotional requirements, the institute found that there was urgent need for a reevaluation of hospital procedures.

For one, the study revealed that the patient seeks to adopt the hospital

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Ernest Dichter, Ph.D.

emotionally as a kind of temporary "step-family," but that in this he is often thwarted by hospital attitudes and practices. Few hospitals have attempted the task of coping with this emotional need, a need that is probably the prime "nonmedical" factor in the patient's stay.

These emotional factors were evident at each level of the investigation. When a cross-section sampling of 160 patients, former patients, and the public was questioned in the course of the study about their general attitude concerning hospitals, 65 per cent admitted that their prime feeling was of fear. When former patients, out of a hospital as much as one to 30 years, were asked to recall their feelings, 68 per cent admitted remembrance primarily of fear.

When a cross section of persons was asked what they would consider the "ideal" hospital, the majority did not mention either hospital standards or equipment. Instead 95 per cent answered that a hospital should be "warm" and friendly; in other words, that it ought to allay their deep fears at the most basic emotional level. When asked how they would describe the ideal hospital, 78 per cent answered "as a kind, firm mother." When describing their complaints, fears and conflicts, or even their joys in the hospital, it was most often in terms of a child's emotional reactions within the "family triangle."

These are the significant findings, for the moment somewhat simplified, of this first comprehensive study to be made into the field of patient-hospital relations.

Put another way, the investigation indicated that no patient walks or is wheeled into a hospital bringing only that single problem of surgery or repair.

The mature adult, finding himself in a situation and environment totally different from the one he knows and is adjusted to in normal life, becomes uncomfortable and, therefore, insecure. His personality changes, and he becomes a child, emotionally. How he reacts to that crisis will affect his recovery. But, in addition, how he reacts will affect his attitude and relation to the hospital. And this attitude, the investigation found, was a keystone of the hospital's relation to the community. It is the cornerstone of such decidedly practical matters as the rate of payment of bills, of the success of fund raising drives, and so forth.

THE PROBLEM

The study of the attitudes and motivations of the patient has, actually, just begun. And the reasons are simple.

Almost all major advances in medical-hospital procedures have been in the area of physical technics. The hospitals have given relatively little thought to the deeper psychological demands of the average adult patient, either upon entering, postoperatively, or in convalescence. As a result the hospitals judge themselves entirely on formal, nonpsychological levels: the number of beds, specialists, procedures, the modernity of the buildings and equipment, the size of the budget, and so forth.

Yet the fact is that the patient almost never reacts to such statistical aggregates. Once in the hospital he seeks satisfaction for his very special and private *emotional* needs. Even before he enters the hospital, he is seeking for emotional assurances on all sides.

We are today in the age of the extensive utilization of trained psychological insights. They are at work industrially, commercially, at the military level, in the political and propaganda sphere, as well as clinically and therapeutically. It is therefore odd that in the profoundly emotional and complex world of the hospital, psychological "self-evaluation" should begin so late.

OUR METHOD

This study is based on five different research methods and five different types of control groups. Our interviews were conducted with 160 respondents of varying ages and educational, occupational and economic backgrounds (see chart).

Research Methods

1. Content analysis: We first exhaustively reviewed and analyzed all available articles on hospitals which have appeared in various newspapers, magazines and scientific literature. We obtained literature from typical hospitals throughout the country on their procedures and carefully analyzed this, too.

2. Insight interviews: We conducted insight interviews with hospital administrators to discover their attitudes toward staff doctors, employes and patients and, by careful analysis, sought to understand how their individual personalities affect the general "tone" of hospital relations.

3. Field observation: Trained psychologists on our staff spent days in the various hospitals observing the hospital routine, attitudes of the staff, and reactions of the patients.

4. Depth interviews: Our main method was the depth interview. This is a psychological technic similar to that used by psychoanalysts and psychiatrists in the clinical situation. Few direct questions are asked but the respondent is encouraged to ramble on in a free-association manner in order to get below the surface rationalizations. The clinical psychologists on our field staff encouraged, by the use of nondirective probing, the expression of all significant feelings, attitudes, fears and desires. The depth interviews gave us an over-all insight into the deep fears and desires of the general public toward hospitals, of the patients' feelings while in the hospital situation, and of the interrelations of the hospital with the community, its employes and staff members.

5. Projective test: Further insight was gained about the hospital personality by the use of our projective testing technic with the patient in the hospital situation. Here we allowed the patient to express freely his feeling about his hospital stay by means of groups of carefully chosen cartoons and pictures to be described later in the appendix.

Control Groups

1. Hospitals in different type communities: We used hospitals ranging in size from 70 to 400 beds, in large cities, wealthy and poor communities and medium sized towns, in industrial areas and in suburban areas.

2. Hospital patients: By projective test we interviewed patients in the varying types of hospitals to gain insight into the differences between hospitals and the difference between patients during hospitalization and after a period of time has passed.

3. Former patients in the community: We interviewed people who had formerly been patients in each of our control hospitals to discover what they remembered and how they felt about their former hospital stay.

4. General communities: We interviewed people in each community to discover how they felt about the hospital in the area.

5. Hospital staff: We interviewed employes and staff doctors in each of the hospitals to get an over-all impression of the relationships of em-

TABLE SHOWING STATUS OF 160 RESPONDENTS TO THE PILOT STUDY

SEX

Male	46%
Female	54%

INCOME GROUP

Under 3000	18%
3 – 5	42%
5 –75	21%
75–10	11%
Over 10	8%

AGE

21–30	18%
31–40	26%
41–50	34%
Over 50	22%

EDUCATION

Grammar School	24%
High School	46%
College	18%
Technical	12%

MARITAL STATUS

Married	73%
Single	17%
Widowed	4%
Divorced	6%

Nº OF CHILDREN

0	18%
1–3	70%
Over 3	12%

OCCUPATION

Professional	10%
White Collar	26%
Skilled	28%
Unskilled	23%
Business	13%

COMMUNITY

No. 1	32
No. 2	40
No. 3	25
No. 4	33
No. 5	30

EMPLOYES

Administrators	7
Office and clerical	10
Nurses	14
Doctors and interns	11

PROJECTIVE TESTS

Male	20
Female	21

ployes and doctors with one another, with special study to see how this relationship affected the patients. Shorthand notes or wire recordings were made by the psychologist during the course of each interview, and projective test, and later transcribed verbatim. The interviews and tests were then analyzed for their psychological meaning in our research center.

Our depth interviews and projective test results gave us a number of insights. It gave us over-all insights into deep underlying emotional meaning of hospitals to the general public, the difference between the patient's current experience and how that experience is remembered, and the effect of internal hospital policies on the patient, the community, and the doctor.

BACKGROUND OF THE PROBLEM

It was found in the institute's study that the very word "hospital" has a tremendous emotional impact on both the patient and public. Persons being interviewed hemmed and hawed when asked about their feelings, but once started in the direction of free association they poured forth an endless stream of emotional material, all stemming from basic insecurity and fear.

One of our most interesting results was that in all responses, regardless of the income level, intellectual level, or specific hospital experience, our respondents had the same basic reactions to hospitals in general. This seems to be indicative of the strong emotional impact that hospitals have on the general population, so strong that it gets below the surface of environmental conditions to the deeper level of basic fears and emotional needs. Moreover, while our interviews usually last for one or two hours, these lasted for three or four. The man about to enter the hospital, and seeking assurances, is faced with this symbolic dread. How he reacts is irrational, as a child.

The root of this feeling lies in the way society handles the hospital. Almost all magazine and newspaper stories concerning hospitals are sensational. They are either sensational "exposés" of hospital failures, or else sensational "reports" of miraculous cures. An equal attitude of the sensational holds in most novels, plays and movies concerning hospitals.

There still exists in the public mind that centuries old feeling that the hospital, as one aged patient put it succinctly, "is a place to die in." The realistic root of this folklore feeling goes back, of course, to the time, a half century ago, when infectious diseases were far more prevalent and deadly. In addition, every former patient who recalls and tells the story of his hospital stay tells a tale that is deeply emotional, highly colored, and symbolic. And this too becomes part of public feeling.

And the hospitals, quite naïvely, add their own bit of emotionalism. They do this by telling the hospital story in terms either of pity or sympathy, or else by stressing the emergency angle of their services. They thus perpetuate the emotional insecurities that surround the concept of the hospital.

Or else the hospitals tell their public relations story with utter dignity and restraint. And in this way they leave the public cold, for they completely neglect the already profound insecurities that exist in the public mind. Actually, the investigation has shown that the patient and the public are seeking certain very simple assurances from the hospital.

THE PATIENT

The most significant finding of the study, as indicated, deals with the regression of the patient to a child's irrationality. It is a result of his basic insecurity. The fact is noticed on the floors and in the wards as an apparently dramatic "change" in the character of the average adult when he becomes a bedded, hospital patient.

It shows up in the patient's constant complaints about food, bills, routine, boredom, personnel—that is, in the general patient irritability. Modern hospitals have made endless attempts at remedying this round of complaints, usually by instituting new physical activities or altering floor procedures. Almost universally they have failed. The complaints go on.

As we probed into the deeper source of these complaints it was found that the whole long list of grievances were only the surface peeves. It was not the coffee, or routine, or lack of routine, that bothered the patient. These were but rationalizations and substitutions for entirely other basic emotional needs.

Over and over in each of the interviews, in one form or another, there echoed the basic cry, "I'm frightened," "I'm insecure," "I need assurance."

As the middle-aged patient at the beginning of this report put it, "Going into the hospital terrified me, you know, white with fear. They give you something, a shot in the arm, and then what happens is that suddenly you have all the same thoughts and fears as before you came in. That

you might die or have a blood clot or something."

And out of this came her unconscious cry for "mother."

One young housewife put it both positively and defensively:

"I get frightened at the idea of going to the hospital—unless it was to have a baby again. Going to a hospital means being sick. And I'm afraid of being sick and incapacitated. I don't like being helpless and dependent on someone to take care of me."

A middle-aged printer in New York put it sensually:

"When I think of hospitals I think of the smell of chloroform, of whiteness, and the atmosphere of pain."

But however it was put, this core of insecurity and fear was universal. It was not, however, simply the fear of dying or of injury that bothered the patient, even when this was what was openly expressed. This must be stressed. For depth-probing indicated that it was also a fear that involved specific infantile insecurities and responses. The patient feared, as much as "death," the sense of being suddenly in a situation and environment over which he had no control. It was a situation in which the adult patient felt frightened, alone, helpless, as some of them stated it, "as helpless as a child."

It is out of this complex insecurity that the patient finds himself, automatically, in a search for the symbolically reassuring parent. This profound search for assurance was found to be the counterpart of almost every expression of insecurity in the study. The search took apparently diverse forms.

One rather hypochondriacal elderly patient received her assurance almost as a child does frightened of the dark:

"I have a horror of ether since childhood; and I was already in the operating room and I asked if I would have ether and they said, 'You leave it to us,' and I was immediately relaxed; I no longer worried about it, even though I wasn't assured that I would be spared the ether."

Another patient in a small suburban hospital said, speaking on the security of "bed":

"Once I was in bed, and being made comfortable, I felt that I was safe. I was in a place where they knew what they were doing, that nothing would go wrong now."

The Insecure Patient Is Frightened by Rumor and Gossip. There are many results of a patient's basic insecurity. In his psychological search for reassuring symbols, or a reassuring situation, he is apt to be easily frightened by certain tales. He becomes like a younger brother listening to nighttime stories intended to scare him. He will fall prey to all the rumors, gossip, superstitions that spread through a hospital, particularly if he does not feel secure, or else he will bring them out of his memory, or simply create them for himself.

One young man grew frightened by reports from an older patient near him:

"The patient in the next bed had the same thing and had had constant reoccurences, both operations and frequent office treatment. Listening to his tale of woe didn't help, especially before the operation took place. This was a very difficult period for me."

The patient probably would not have felt so helpless if his originally deep insecurities were being ameliorated by the hospital, if certain basic assurances were given him. This particular patient was profoundly upset:

"I had a disease in that area which caused me an anxiety that it would reoccur, and that my sexual potency would be affected."

It was found that the patient reads meanings into all he sees and hears. The psychological atmosphere of a ward or hospital transmits itself clearly to the patient. He reacts strongly, even in a short stay, to an endless series of incidents that never appear in the records and reports.

Other Aspects of the Patient's Search for Assurance

The adult's regression to a child's helplessness and dependence, and his search for symbolic assurance, were the basic findings concerning the patient. But though it was the strongest finding it was only partial. For there were variations of the pattern in each hospital, as well as in individual patients.

The individual personalities of each hospital, for instance, drew forth distinct responses. Each patient also exhibited other security and assurance-seeking patterns, some of which, at first glance, seem to contradict the "child-patient" pattern.

It required an astute clinical probing, for instance, to determine that while the patient became so largely a child, this very status set up a deep conflict within him in his attempt to maintain his image of himself as an adult. "I'm not a child after all," he seemed to be trying to say.

The Wish to Be an Adult. At each stage of the hospital stay various patients reacted strongly against threats, real and implied, to their individuality, maturity and adulthood. Both the threats and the reactions took varying forms.

A robust, hale and hearty man of middle age, who had for a lifetime thought of himself as entirely independent, expressed appreciation of the fact that in his hospital his adult independence was not threatened:

"The reception routine was fine. Everyone was very sympathetic, without being sentimental. That is, they seemed to understand what they were doing, they spoke nicely to me but they didn't gush over me. That is something I couldn't stand."

A restrained, intellectual young man in another hospital complained that:

"Being treated like kids intensified the feeling of helplessness, especially when the patient is already confined to bed and is helpless to begin with."

While many patients expressed this initial fear that they *might* be treated too *solicitously*, or too much "like a child," thus threatening their adulthood, not one patient of all those interviewed complained that he had actually received too much consideration or *care*. This need for care was primary. Even in the case of the young man above, who complained of "being treated like a kid," he was in actual fact complaining that he was being told what to do and when to do it, and he was therefore frustrated precisely because the attitude was too impersonal and authoritarian and not warmly considerate enough.

This young man was hurt both by his childlike helplessness, and by what he considered a slight to his mature individuality. The study seemed to indicate that *there is no such thing as "too much" care*. It is the *quality* rather than the *amount* of the care that the patient is wary of. It is the *attitude* rather than the procedures themselves to which he reacts.

The Patient as Incomplete Individual. Another insecurity in the patient syndrome, it was found, was that he took the injury or breakdown of his body symbolically, sometimes as a sign of failure, or of aging, or of retribution, and so on.*

(*Continued on Page* 136)

*This sense of injury, and insecurity, did not hold in situations of childbirth. Here there were other symbolic structures, and different assurance-seeking processes.

Dr. Wallace Graham, Mr. Truman's personal physician, seated at the head of the table with Mr. Adams at his right, is interviewed by newspapermen.

"V.I.P." in the Hospital

Spells Very Intricate Problem in press relations

SUSAN S. JENKINS

Executive Secretary, Kansas City Area Hospital Council, Kansas City, Mo.

EMERGENCY admissions late at night aren't news at a hospital, but the admitting clerk at Research Hospital, Kansas City, Mo., took a good long look at Case No. 90286 that Saturday night, June 19. Harry S. Truman . . . Independence . . . nearest relative, Mrs. Bess. . . . Took a look and lifted the phone to call Robert E. Adams, administrator, at his home.

But Mr. Adams already knew. By that eerie prescience which is the trademark of the press, the hospital admission was known before it even happened. And the administrator had already had a call from a reporter who said, "Did you know Truman was a patient in your hospital? When do we get a bulletin on his condition?"

That was the beginning of a turbulent three weeks that in Mr. Adams' book ranks right up with at least a minor catastrophe.

The Trumans didn't want any special favors or extra service. They wanted to be treated like any other family. For a very sick man, they wanted privacy and seclusion. Any patient has a right to that, says the press code of the Kansas City Area Hospital Council. Only if family and physician both agree will news be given out about a patient. But Bob Adams was to find that press codes mean nothing when the patient's name is news in every corner of the world.

Sunday morning Mr. Adams decided he ought to get to the hospital early, just to shoo away any reporter who might be hanging around. For word had come from Dr. Wallace H. Graham, Mr. Truman's doctor, that the patient was to have absolute quiet. No visitors, no phone in the room. Complete privacy. And while the door to room 323 was tightly closed, there was a swarm of people in the corridor, downstairs in the lobby, at the information desk, the switchboard. Men with cameras and flashbulbs and notebooks.

And not only the press. There were friends, acquaintances, business and political associates, and dozens of just curious people who wanted to see what was going on.

Mr. Adams retreated into the relative quiet of his office; tried to sort out the newsmen, explaining that they couldn't be allowed on the patient floors and why. The hospital was crowded, beds in the halls. The family had requested no visitors, no photographers, and their wishes had been confirmed as an order from the doctors.

But the press knew that Mr. Truman had undergone heavy surgery in the middle of the night. Dangerous surgery at any age, the removal of appendix and a gangrenous gall bladder was particularly so with a 70 year old patient. And besides, the Truman name was *news*. They had a right to know how he was. The public had a right to know. And the hospital had no right to withhold that information!

A bewildered administrator knew he had a situation on his hands that wasn't going to be solved by any local code of press relations. He managed to bluff through that first day, finding the press cooperative about staying off the floors, but persistent and vocal in their demand for news. It was midnight Sunday before Mr. Adams could leave for home.

The next day the administrator called a meeting of all department heads and said, "This is a real emergency and we've got to treat it as such!" He invoked the hospital's well worked out disaster plan, using the same communications channels as for fire and other major catastrophes. The word went out to all the staff: "Don't discuss Mr. Truman's condition with anybody under any circumstances! Carry on your work as usual."

That's exactly what was done, but it wasn't easy. There were problems galore.

Mr. Adams knew there must be set up an orderly method of giving

out press bulletins. Conferring with the doctors on the case, the matter was referred to the public policies and relations committee of the county medical society. Could the doctors make the releases? The answer, an emphatic "No." Who would do so? At the request of both physicians and family, the administrator was designated to do it, despite his protests and those of the press.

Things might not have been so bad had it not been for the patient's worsening condition. After several days of seemingly uneventful recovery from the surgery, trouble began to develop. Temperature elevation. A gastroenteritis. Hiccoughs. Sensitivity to a wide range of antibiotics. Finally, the word "critical" began to appear in the bulletins and the situation became tense.

All the major news services were represented. The *New York Times* and the *Chicago Tribune* each had a man on the spot. So did *Life* magazine. And of course all the radio and television networks. They set up a 24 hour siege, in the hospital and outside, even though the regular press conferences were set only for 10:30 a.m. and 8:30 p.m. If the light in the Truman room burned brightly all night, there was a barrage of questions at the next morning's conference. Why? Was he worse? Was there some special treatment being given? If so, what was it?

Everywhere there were complaints from the press: to Mr. Adams, to the trustees, bitter complaints to the Area Hospital Council. Who did Adams think he was, anyway? Why did a hospital think it could deny information to the press? Sure, they knew a patient had a right to privacy but the public had a right to news!

When Mr. Truman's condition was gravest the press, through sheer force of their protests, demanded and got an interview with Dr. Wallace Graham, the surgeon and Mr. Truman's long-time personal physician. It was the only such conference that was granted.

In the meantime there were problems on other fronts. There was the handling of mail. It came in first in bundles, then a mail sack full, and finally many bags of mail. Letters bearing stamps and postmarks from every corner of the world. In desperation Mr. Adams called the post office. Couldn't they help somehow? They could and did. Alex Sachs, postmaster, came out and looked over Research Hospital's modest mail department. Decided it couldn't possibly cope with the volume. He arranged to have all the mail diverted to Mr. Truman's office in downtown Kansas City where office staff and volunteers among friends sorted it first, sending only the more intimate messages to the hospital.

Would Western Union do the same? It would. Telegrams were routed to the Truman office, even though addressed to the hospital.

Messages poured in from Hollywood and London and Jerusalem and Washington. From Anthony Eden and Churchill, from Jose Iturbi and Jimmy Durante and the Douglas Fairbanks' in London. From heads of state and ambassadors and from just plain ordinary folks who wanted to send their good wishes.

Stormiest spot of all was the hospital switchboard. There was no way to divert phone calls. The operators simply had to take them all. And with an already busy and overburdened hospital board, it was brutal. All the operators worked long hours of overtime, doubling up and staffing telephone stations where the calls could be sifted. The important ones had to be sent on up to Mrs. Truman. Most of them were simply recorded and the caller given the latest bulletin on the patient's condition.

It was heroic work that the switchboard team did, and even the press complimented the operators on a fine job.

For Mr. Adams, long days became routine. He was at the hospital by at least 7 every morning, rarely left before midnight. He visited Mr. Truman regularly three times each day; talked with Mrs. Truman; got a press statement from the doctors; saw that proper service was being given. Mrs. Truman steadfastly refused any special favors, as did the patient himself. When his illness became critical he was moved, over his protests, to an air-conditioned room. A conference room was made available for the doctors and close friends of the family.

Patients housed in the corridor outside room 323 hated to see Mr. Truman moved, too. They said Bess Truman was so nice; told how she would stop and visit with each of them every day; how she gave them flowers from the great abundance sent to her husband.

But behind that closed door, the patient's day went on just like that of any other patient in the house. No whisper was allowed to reach Mr. Truman that there was any upset in routine anywhere.

Twice a day, the formal, walnut paneled board room of the hospital was turned into pandemonium. Against a backdrop of severely framed photographs of past board presidents, the paraphernalia of cameras and microphones set an incongruous note, while the hot lights for the television cameras made the already high Kansas City temperatures almost unbearable. Men in short-sleeved sport shirts scribbled busily as Mr. Adams read the short sentenced press release, then voices tumbled over one another with questions. And always the complaint that there was too little information,

Twice a day in the board room of Kansas City's Research Hospital, Administrator Robert Adams (at head of table) read a short-sentenced press release and answered the questions fired at him by reporters.

and why couldn't all the doctors on the case be interviewed? Actually, the only doctor's name ever given out was that of Wallace Graham. The others were withheld on the instruction of the medical society.

By the third week the patient was on the mend again and things settled into a semblance of serenity. The loud remonstrances had subsided to a low grumbling with only an occasional outburst. There were continued efforts to get information from hospital employes, who nonetheless went about their duties as if nothing was happening to disrupt routine. From the avidly curious, Mr. Adams himself was offered a few bribes for an inside story about Truman, the patient.

Things were quiet until the final outburst the day Mr. Truman went home. Newsmen had been on the extra alert that last day or two. Bulletins had clearly indicated the hospital stay was about over. Every photographer was on his toes for that one picture he might hope to get—Harry Truman walking down the corridor and out to a car. Every news service was on the *qui vive* for one final big chance.

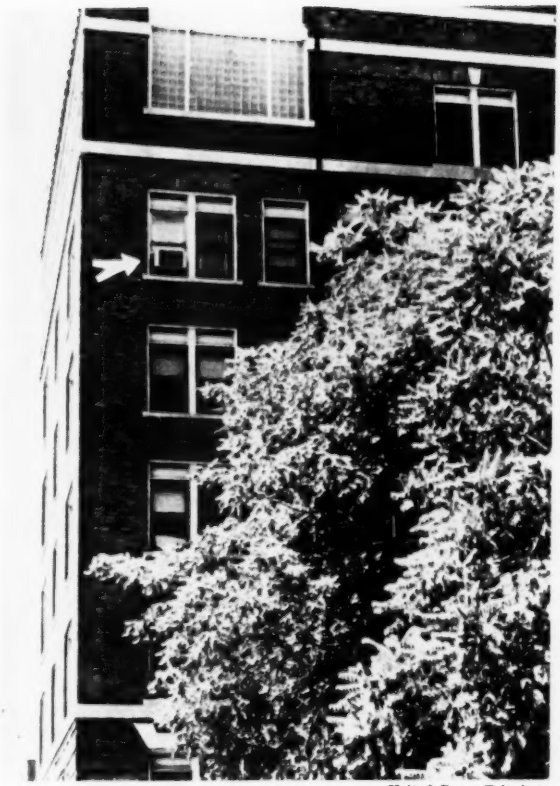
Only they slipped somehow. At 5:30 a.m. a car quietly slipped up to the ambulance entrance and met a patient who had disdained a wheel chair and insisted on walking to the elevator and out to the car.

It was over, all except for that final press release. The family had asked that enough time be allowed for them to get settled at home before the press was notified. So, Mr. Adams thought about 8:30 a.m. would be right.

An hour before that time, Mr. Adams' phone rang. It was a reporter. An irate voice demanded to know how come Mr. Truman had been home for nearly two hours now and not one word from the hospital!

Oddly enough, when the hue and cry had died down a few days later, this final complaint remained the most vivid in the eyes of the newsmen. To them it was an unnecessary breach of faith; a demonstration of the complete failure of the hospital administration to understand their problems, even though the press did not understand the hospital's first obligation—the patient.

Randall Jesse, director of news and special events for the *Kansas City Star* radio and TV, veteran newsman and "stringer" for the National Broadcasting Company, commented. "We felt that Truman's leaving the hospital was badly handled. We could have been notified much earlier and still have had enough time for the family to get settled at home. They just didn't appreciate that minutes are important to the press."



Arrow points to the air-conditioned room in the hospital to which Mr. Truman was moved when he became critically ill.

United Press Telephoto

Mr. Jesse went on to say that on the whole, however, newsmen thought the hospital did a pretty fair job, considering the problems it was up against. He wasn't happy with the idea of an administrator giving press bulletins about the condition of the patient, but neither was Mr. Adams. "That should have been done only by one of the doctors on the case," said Mr. Jesse. Then he spoke about the one spot where there was no criticism at all to be made. "The switchboard operators and information clerks were wonderful," he said. "They were always courteous and helpful."

Looking back at the experience, Mr. Adams sees a lot that was done wrong. What would he do differently if it happened again?

"First," said Mr. Adams, "we'd call a press conference immediately. Not the next day, but in the middle of the night if necessary. We'd find out what the reporters want, how they want bulletins set up, what their filing deadlines are. In other words, we'd try to understand their position thoroughly. Then we'd carefully explain our side of it: What the patient's privileges are, what the hospital policy is, what information we can and cannot give. And we'd try to make it clear what we mean by words like 'fair,' 'serious' and 'critical.' They just couldn't seem to understand them."

A whole new procedure for handling V.I.P.'s is going to be set up in the hospital's disaster plans, according to Mr. Adams. There will be problems to work out, like getting the medical society to allow a doctor to make news releases, but a carefully spelled out plan should eliminate complaints and criticisms.

Not that the press was unreasonable, said Mr. Adams. He felt they were unusually cooperative. "It's just that we didn't understand their operation and they didn't understand ours. I guess each of us learned a good bit about the other."

In the meantime, unaware of the hubbub his stay had caused, a tough and game 70 year old patient was on the road back to health. Like a million other patients, his only comment was, "It's good to be home!"

Commission Criticizes Hospital Schools

Study of university programs in hospital administration reveals many shortcomings, shows need for liberal education as background for admission to hospital studies

EVERETT W. JONES

PUBLISHED this month, the report of the Commission on University Education in Hospital Administration* is sharply critical of many practices in all the university programs in hospital administration. The report stresses lack of adequate financial support by the universities, the lack of qualified faculty members, the absence of full-time directors and assistant directors, the widely varying ages and heterogeneous background of students, the absence of clearly defined and written objectives of the programs, poorly organized teaching methods and materials, and many other facets of the current programs. Urged as a necessary and highly desirable goal for students seeking admission to graduate programs in hospital administration are a more thorough foundation in administrative skills and a broad, liberal undergraduate education.

The graduate teaching programs should include a more thorough study of administrative principles, problem analysis and solving, analytical know-how, decision making, and other proven management tools—all to be taught through small group seminar methods, the commission recommends.

The report is particularly critical of programs located in schools of public health. "The seven programs located in schools of public health carry a disproportionate number of public health courses," it stated. "In example, the approximate average amount of total class time devoted to public health and medical subjects in the programs of schools of public health is 42 per cent, as contrasted with 13 per cent in the programs located elsewhere. In most of the programs located in schools of public health this prescription or influence, which has not favored the growth of the programs, has been excessive."

The commission is made up of hospital trustees (employers of the products of the programs), hospital administrators using widely different patterns of preservice training and different methods of administrative residency training, a representative of the public health field who has had considerable experience in public health methods and administration and is a program graduate, a representative of organized education on a national scale, and three members who are professional educators in the field under study and hospital administrators and consultants. The 18 month study was directed by Herluf V. Olsen, long-time dean and professor of the Amos Tuck School of Business Administration at Dartmouth College. Professor Olsen was assisted by John Nicklas, a recent graduate of one of the programs and an assistant hospital administrator. The broad, practical experience and educational backgrounds of all connected with the commission give great validity to its findings.

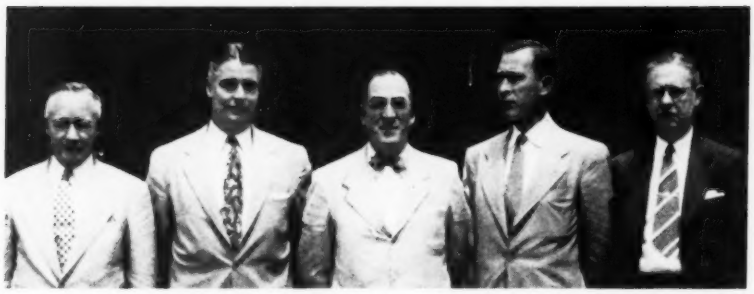
The commission study was the result of efforts by faculties of the several programs and the American Association of University Programs in Hospital Administration to obtain a critical analysis of their work and competent recommendations for future improvements. Costs of the study and publication of the findings were met by the Kellogg Foundation.

The commission members are: James A. Hamilton, chairman, hospital consultant and director, program in hospital administration, University of Minnesota; J. Milo Anderson, administrator, Ohio State University Health Center, Columbus, Ohio; Donald G. Borg, editor and publisher, *Bergen Evening Record*, Hackensack, N.J., hospital trustee; Francis J. Brown, staff associate, American Council on Education, Washington, D.C.; Ray E. Brown director, program in hospital administration, University of Chicago, and director, University of Chicago Clinics; Dr. James P. Dixon, commissioner of public health, Philadelphia, and assistant director, Clinical Center, National Institutes of Health; Dr. John E. Gorrell, formerly assistant director, program of hospital administration, Columbia University, New York, con-

COMMISSION RECOMMENDATIONS:

1. The hospital programs should have more support from parent universities.
2. Programs need definitive statements of their educational objectives.
3. Students should be younger, with liberal and administrative education.
4. Programs should be located wherever possible in schools of business.
5. Curriculum should emphasize broad principles of administration.
6. Residency training needs closer integration with rest of program.
7. Teaching should be characterized by "seminar approach," fewer lectures.
8. Faculties and students should have opportunities for hospital research.
9. Program director should be full time, fully qualified in education.
10. Programs should aim at bringing hospital schools up to status of other professions.

*"University Education for Administration in Hospitals." A report of the Commission on University Education in Hospital Administration. Published by the American Council on Education, Washington, D.C., 1954.



Some of the members of the Commission on University Education in Hospital Administration, left to right: Dr. Francis J. Brown, American Council on Education; Prof. Herluf V. Olsen, study director; James A. Hamilton, University of Minnesota; Donald G. Borg, publisher, *Bergen Evening Record*, Hackensack, N.J., J. Steele Gow, Falk Foundation, Pittsburgh.

sultant for medical services division, National Foundation for Infantile Paralysis, New York; J. Steele Gow, executive director, Maurice and Laura Falk Foundation, Pittsburgh, and trustee, Children's Hospital, Pittsburgh; Leon N. Hickernell, director, Vancouver General Hospital, Vancover, B.C. **Study Staff:** Herluf V. Olsen, director, professor, Amos Tuck School of Business Administration, Dartmouth College, Hanover, N.H.; John M. Nicklas, assistant director, assistant director of Roosevelt Hospital, New York City, and Katherine Brock, administrative assistant, Orford, N.H.

Throughout the report, the great importance of centering educational efforts around broad administrative principles is stressed. Such an educational program can best be carried out in schools of business administration, rather than within schools of medicine or public health, the report contends. Sharp differences of opinion on this aspect of the report were expressed at a recent meeting of representatives from all the university programs. The undergraduate educational program recommended by the commission would keep doctors of medicine and graduate nurses out of the courses, some of the representatives held. In this connection the report discusses the possibility of a graduate program for doctors and nurses only, and says, "Some feel that exceptions should be made in the admission requirements for doctors of medicine and nurses having bachelor's degrees, in view of their previous training and knowledge of medicine or nursing, the length of time they have already devoted to education and the urge to attract more of these persons to the field of hospital administration. A program might be designed exclusively for doctors and nurses, eliminating the environmental courses of the academic period and expanding the administration courses to begin at a lower level than is proposed in this report. While this may be more attractive to the physicians and nurses before admission, it might prove to be less beneficial to them in the long run than the program proposed herein.

"The environmental knowledge they have gained from their previous training has not been acquired from an administrative point of view. The contact with fellow students of the affiliated disciplines would be lost. Likewise the value of association with physicians and nurses would be lost to the students of the other programs. Furthermore, an academic period of nine months would not be adequate to bring these students to the same point of development at the end of the academic year as would be reached in the program proposed herein. Also, such an endeavor would be extremely hazardous for a university to undertake if future experience follows the past experience of having a limited number of physician and nurse applicants. Some propose lowering admission requirements on all programs for this special group. The program proposed in this report could not be attained in such circumstances." The degree program recommended in the report, Dr. Olsen explains in the introduction, "is intended as a guide and a helpful pattern and not as a strait jacket or a rigid pattern to which all must conform in detail."

The report opens its chapter (XVI) on "Limitations of Existing Programs" by briefly discussing the growth of hospitals from the first hospital census of 1873 which listed 149 institutions to the present listing of 6900 units. "As the hospital industry began to assume increasing importance in the national economy, a concern about management in the industry was expressed in the scattered and uncoordinated development of apprenticeship plans under the more farsighted executives in the field," it is explained.

These plans were Step 1 in the hospital administration program. The shift from apprenticeship to our present university programs was the second stage in the transition from a vocational to a professional base. "Today all the programs may be said to be at varying points in transition from the second stage to the third stage, which is characterized by introduction of the professional educator and by complete integration with the university," the report says.

Because 11 of the 12 programs were begun during or after World War II, they had many applications from older students. At the same time, there was a demand from hospitals for more and more trained administrators. Because of these facts, it is stated, "the programs in focusing upon the immediate needs of the industry have established admission requirements of considerable latitude. . . . Due to the extreme diversity of background displayed by students admitted to the programs, no common foundation can be found for graduate work. Most of the programs have not stated in written form in catalogs and other notices what specific undergraduate preparation will be of greatest value to the applicants as graduate students and the particular abilities and qualities they should have acquired in the undergraduate years that will assist them both as graduate students and as administrators."

The report criticizes the preference for older students and points out that failure to recruit younger students right out of undergraduate work is causing a loss of many high grade candidates for hospital administration.

Among the critical findings of the commission, covering all aspects of the educational programs, the following are emphasized in the report:

Curriculum

1. Widely varying ages of students (22 years to over 50) and their widely varying backgrounds of undergraduate education. Lack of fundamental

education in administration has made difficult if not impossible the development of sound graduate programs.

2. In order to provide a common educational base on which to build, the programs have been forced to devote a part of the graduate academic year to accommodate foundational work in administration. This has resulted in limitation of the work in both foundational and graduate studies.

3. Most programs located in schools of public health (seven out of 12) carry too many hours of instruction in public health. This in turn makes impossible enough courses in administration and management. As the report states repeatedly, the primary job of the programs is to train students in administrative principles and to teach them how these principles can be applied to the successful operation of hospitals.

4. Too much vocational detail. "The programs in formulating curricula have chosen to think primarily of the immediate needs of the industry and to emphasize technics rather than basic principles. . . . For inculcation of the art and science of administration the programs have relied too heavily on the preceptors of the residency year." The report summarizes curricular criticisms by saying, "The emphasis on practical, departmental and mechanical aspects of hospital operations, when coupled with the necessity of remedying the deficiencies and shortcomings of the students on admission, plus including an excessive number of public health courses in many of the programs, has left little time for the type of study which should characterize the graduate year—that is, the analysis and solution of case problems involving administrative decision making, policy formulation, human relations, control and evaluation."

Teaching Methods and Materials

1. Again the difference in ages of students is emphasized as an obstacle in teaching.

2. "Much of the subject matter, content, methods and materials of the hospital administrative courses has been on a didactic, descriptive level which has left little time for group and individual developmental work in the form of problem solving, seminar work and individual report preparation of a type not restricted to forms of administration."

3. Not enough use is made of prominent journals and good books in the field of administration.

Class Size

1. "Financial pressures were responsible for the maintenance of a high admission rate in at least two of the four programs admitting in excess of 15 students per year. Seminar discussion groups are too large for effective teaching."

Faculty

1. "One of the most severe limitations of the programs is the inadequacy of their faculty staffing in relation to the job they have attempted."

2. Too much of the teaching is done by visiting lecturers, resulting in great difficulties in coordinating subject matter in the various courses.

3. "The greatest difficulties, as one would expect, are presented in the schools of public health, which are organized primarily to orient and train persons already possessing professional training and experience in public health matters and not in administration *per se*."

4. Faculty members in hospital programs do not have enough contact with faculties of other schools in the university.

5. The relationship of hospital programs with their universities is rather tenuous.

6. There are too few full-time directors and assistant directors.

Financial Support

1. Schools depend too much on sources other than the university for funds.

2. There is not enough money to employ competent, full-time faculties.

Residency

1. Too many residencies are inadequate.

2. "In too many cases the inadequate residency year may be, variously, a year of apprenticeship, a year of on-the-job training, a year of orientation to the hospital, or a combination of these, depending upon the interpretation by the various hospital administrators serving as preceptors and by the directors of the programs. It can be a year of relative waste or a year of unusual profit to the student and, for that matter, to the preceptor, to the hospital and to the university."

3. Too many students are exempted from the residency year. One program permits a medical education to be substituted for field training in hospital administration. One wonders what there can possibly be in a medical education to fit a person for administration.

4. "Actually the residency experience has not been an integral part of the programs. It has appeared merely as a sequence."

5. Each program uses too many preceptors, resulting in lack of full understanding between program directors and preceptors and making an educational program for preceptors almost impossible.

6. Value of annual visits by a program faculty member to residency hospitals (seven of the 12 programs make such visits) is doubtful.

7. Programs do not exercise enough control over residency period. The program recognized limitations existing in residency training by asking the American College of Hospital Administrators to develop a manual covering the training for hospital administrative residents. "This manual, which is a well executed and valuable contribution to that part of the educational program which is not university centered, does not of itself suffice as preparation of hospital administrators for preceptorship."

Publicity

1. "One of the handicaps which the programs have had . . . is that of being unpublicized, hence largely unknown to the undergraduate student body from which they have been drawing progressively more of their students."

2. Too many programs do not have their own descriptive catalogs.

3. "The limitations of small staffs, little time, and restricted funds have all operated to inhibit strong publicity efforts either within or outside the universities on a national basis." This has, of course, limited the number of desirable students applying for admission.

Chapter XVII of the report gives decisive recommendations for improvement of all programs. "The need for the programs, which grows daily in a world of constantly increasing complexity, cannot be gainsaid," says an introductory statement. "Maintenance of the voluntary nonprofit corporations, which are at once beneficiaries and preservers of our economic and social system, demands the

(*Continued on Page* 138)

The business offices of Methodist Hospital, Memphis, Tenn., present an appearance of cheerful spaciousness and a brisk, businesslike atmosphere.

For more efficient business office procedures

This Plan Was Borrowed From the Bank

C. HENRY HOTTUM Jr.
Assistant Administrator, Methodist Hospital, Memphis, Tenn.

THE new business office of Methodist Hospital, Memphis, Tenn., was planned on the order of the modern banks. Offices for admission clerks, cashiers, insurance and collection clerks, office manager, information clerk and credit manager, administrative residents and assistant administrator are separated by walnut paneled counters. These offices together with the lobby occupy the entire first floor of the new north wing. This wing is the main entrance to the hospital and is free of full partitions, affording a cheerful spaciousness with good cross ventilation and ample lighting.

The original structure of Methodist Hospital in 1924 at its present site provided 125 beds. During the years, additions to the hospital have increased the bed capacity to 300. The main wing of the hospital is about 450 feet long and runs parallel to Union Avenue, one of Memphis' main thoroughfares. The hospital was built about 200 feet back from the street providing a spacious lawn covered with trees.

As the hospital has been enlarged through the years, the business office (as planned for 125 patients) became overcrowded and decentralized. It was necessary to add to the original busi-

ness office some small rooms in various sections of the hospital. This arrangement did not permit a smooth flow of work through these offices, which resulted in an inefficient use of office personnel time and made proper supervision more difficult.

Inasmuch as similar conditions existed in x-ray and laboratory departments, the building committee planned the modernization of all three departments through the building of our north wing, providing adequate facilities in each of these three departments to care for some future increase in the number of beds. Plans for the north wing were drawn by the Office of Walk C. Jones Jr., architect, Memphis, Tenn.

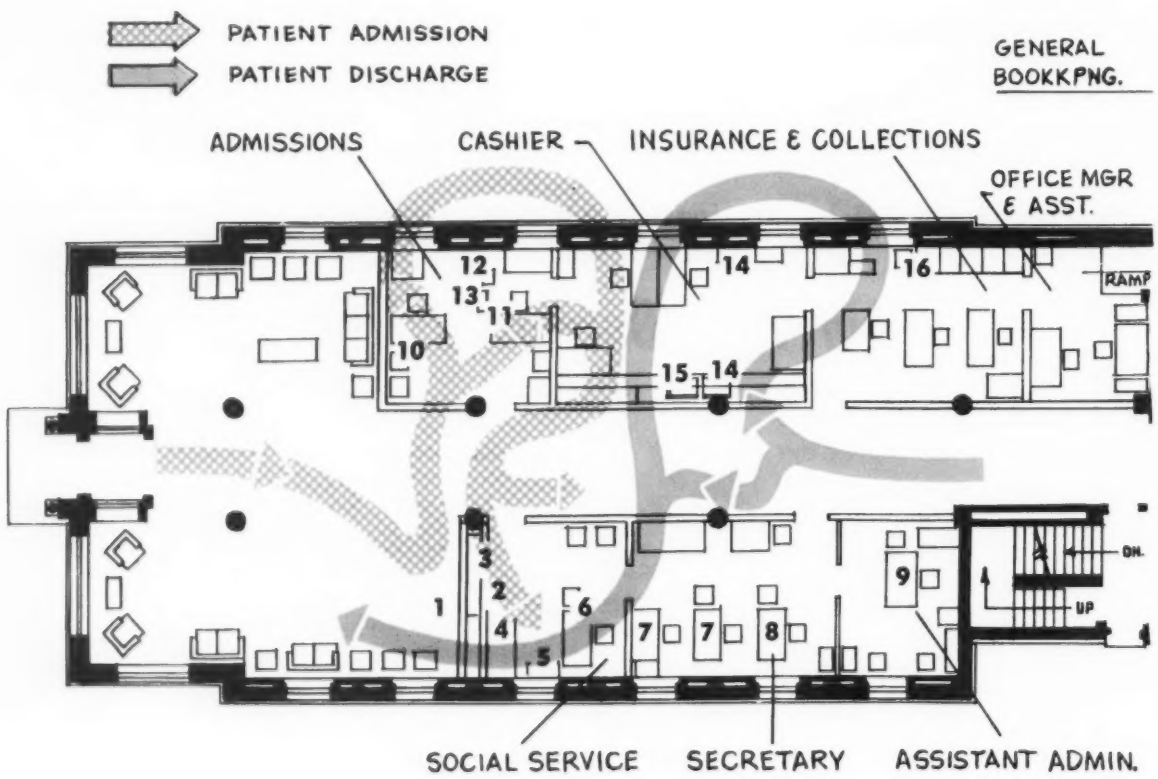
The north wing, completed in 1950, is about 90 feet by 43 feet, and like the rest of the plant includes four stories and a basement. The new wing was built in front of the old entrance at right angles to the main wing and extending into the front lawn about 90 feet. This revision brings the main entrance closer to the street and has increased the number of patients and visitors using the front entrance in preference to side or rear entrances.

Patients entering our hospital for admission go first to the hostess or clerk typist at the information counter (Desks 3 and 4). If the admission clerk is busy, the hostess invites the patient to have a seat in a lobby chair near the information counter. As soon as the admission office is clear, the hostess invites the patient or relative to go into the admission office. The admission clerk (at Desk 11) types a 13 part multiple admission set. If the patient has insurance, he is referred to the insurance clerk, in the same office (at Desk 10), to make an assignment of benefits to the hospital, while the admission clerk cuts a plate on the addressing machine (12).

When the admission or insurance clerk decides a deposit should be invited, the patient is escorted to the cashier in the adjacent office, which is just across a counter from the admission clerk. If the patient is unable to make the requested deposit, he is referred to the credit manager (at Desk 6). The hostess and clerk typist are in the same office with the credit manager and either one of them acts as receptionist for the credit manager. The desk of the credit manager is in the far side of this office to permit private conversations. When the necessary business arrangements are completed before admission, the hostess escorts the patient into the inner lobby where a picture of Christ healing the servant of the centurion may be seen before the patient enters the elevator to go to his room.

In addition to the duties described, the hostess handles all incoming and outgoing mail for the hospital, while the clerk typist relieves at the information desk in the absence of the hostess and performs other clerical duties.

When a patient is discharged, he or his relative returns to the business office to obtain his final bill and pay or make arrangements. His bill can



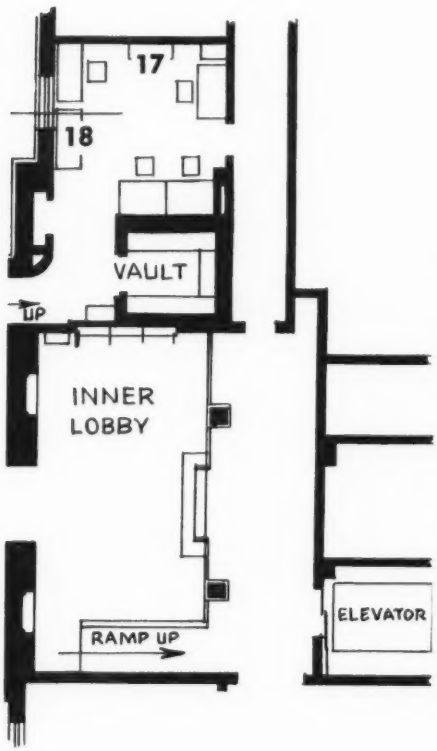
Plan of the business offices, with the flow of traffic illustrated by dotted lines for patient admissions, and solid lines for discharges. Centralization of related offices permits more efficient performance of duties.

be obtained from a cashier, who also posts the patient's accounts receivable. The cashiers' counter is is about 1 foot higher than the other counter-partitions dividing the offices; two counters are provided—one for the patient and one for the cashier. Patients stand in the aisle and are waited on by cashiers on either side of the cash register (15) and the bookkeeping machine (14) which are centered in the cashiers' counter. A second bookkeeping machine (14) is at the back of the cashiers' office. A patient on discharge may either pay his bill at the cashiers' counter and leave the hospital or, if he has any question concerning the charges or the collection of his insurance, he is referred to a clerk in the insurance and collection office adjacent to the cashiers. If the patient being discharged needs to make any arrangements for the payment of the balance of his account, he is referred to the credit manager before leaving the hospital.

Locating the cashiers' office between the admission office and the collection office permits the cashiers to be readily available to the admission office for

The picture of Christ healing the servant of the centurion is at the head of the stairs as the patient enters the elevator.

The main entrance and the lobby of the hospital where patients may wait until the admission clerk is able to take care of them.



taking deposits on admission as well as to have the accounts of discharged patients conveniently accessible. The accounts of discharged patients are kept in the insurance and collection office in open box files that are closed only at night. When the sliding top is closed the ledger trays are lowered into the files at night and locked. These open files permit the ledgers of discharged patients to be convenient to cashiers when payments are received on old accounts, as well as to the personnel in the insurance and collection offices who assist in processing insurance claims and the typing of collection statements.

The office manager and assistant office manager occupy an office adjacent to the insurance and collection office. From his desk the office manager can see all employes waiting on the patients and the visitors. This permits better supervision. In addition, the office manager is convenient to the vault and the general bookkeeping office, which are in the old wing of the hospital. In the general bookkeeping office, the daily bank deposits are prepared and the general ledger, accounts payable and pay-roll work is done with the aid of bookkeeping machines (Nos. 17 and 18). The assistant administrator also has his office in the new north wing (Desk 9). This provides additional supervision and makes the assistant administrator readily available for consultation in case of serious complaints. The secretary to the assistant administrator (Desk 8) writes the collection letters and also has convenient access to the files of discharged patients' accounts.

We feel that our new business office has been successfully modernized in that it is functioning as planned. We have increased the number of patients and visitors using the front entrance. The unification of lobby and business office gives our patients and visitors a favorable first impression in a well lighted, cheerful and spacious area that is made more attractive through the use of soft recorded music heard throughout this area. The public has free access to all departments of the business office. The flow of work through this area is much more smoothly accomplished because of the centralization of related offices, which permits more efficient performance of duties by the employes and more efficient supervision.

The Utilization Committee

will help to keep the use of hospital facilities in bounds and reduce costs proportionately

FRED G. CARTER, M.D.
Vice President in Charge of Development
St. Luke's Hospital, Cleveland

MOST of us in the hospital field are familiar with the improvements that have taken place in the handling of surgical patients, in particular, since the advent of the so-called "tissue committee" in medical staff organization. For many years all good hospitals have required that tissue removed at operation be referred to the pathological laboratory for examination and report. The idea back of this procedure has been largely to bring to light instances of unnecessary surgery or faulty surgery. Theoretically something would be done about adverse findings. The difficulty has been that pathologists occupying a highly sensitive spot in the staff organization were left largely to their own devices in attempting to exercise any kind of disciplinary control in such matters. They found the situation most unsatisfactory.

Someone came up with the idea that a staff committee consisting of well established members of the active staff could be helpful in such matters. The pathologist could report his findings to such a committee for review and for such action as the committee might deem advisable. This committee now has been recognized as one of the essential components of good staff organization and has come to be known as the tissue committee. Its influence in hospital and medical circles has been a most salutary one, and the arrangement has spread to hospitals all over the country. It is looked upon with favor by the hospital accreditation commission.

We have long since reached a point where we must come to grips with another great problem in the hospital field. This is the problem of hospital costs. Much has already been done in this area but what might prove to be a fruitful line of attack on this problem either has been overlooked, hasn't been emphasized sufficiently, or hasn't been properly implemented. Why not apply the tissue committee idea to hospital utilization? Why not appoint a standing hospital staff committee designated as the "hospital utilization committee" to do in the field of hospital and medical economics what the tissue committee does largely in the field of surgery. Abuses in the use of hospital services and facilities coming to the attention of this hospital utilization committee could be disciplined to the point of near deletion—and all to the advantage of everybody concerned, including doctors, patients and hospitals.

Doctors are responsible for the admission and discharge of patients, for ordering medications, for requisitioning ancillary services of all kinds. To a large extent they control the costs of hospital care.

WHEN PATIENTS HAD TO PAY

When patients had to pay the entire cost of hospitalization out of their own pocketbooks, they and their doctors were more careful about what was ordered for them. Under those circumstances perhaps too much restraint was exercised. Now when from 60 to 80 per cent of our patients have their hospital bills paid for them in large part by third party payers, such as Blue Cross, private insurance companies, and others, the pendulum has swung to the opposite extreme. Hospital laboratories are swamped with requests for tests of all kinds. Technicians, overburdened, look for short cuts. The accuracy of their work is impaired. The whole laboratory function becomes diluted, and its value declines in proportion to the dilution. Personnel shortages add to the trouble encountered.

Patients requiring diagnostic work oftentimes are admitted to hospitals needlessly as bed patients in order to permit them to take advantage of Blue Cross or other insurance coverage. This practice also accounts in part for mounting subscriber rates in Blue Cross plans and for increasing hospital charges as well. Frequently too much time is lost between the time a surgical patient is admitted to the hospital and the time of his operative procedure. Discharges are often delayed simply because the doctor doesn't sign discharge papers promptly when hospital care is no longer indicated. Some doctors feel that they have priority on beds from which they discharge patients. Some have been known to order hourly temperature readings just to assure hourly attendance upon their patients. A few appear to use ancillary services as a sales approach, the theory being that the patient's regard for their abilities will be in direct proportion to the number of tests they order for them. Such practices not only boost costs but are unfair to all patients as well as to the vast majority of staff members.

Doctors knowing that the eyes of a vigilant hospital utilization committee were upon them might be inclined to think twice before ordering any kind of hospital care or service. Deviation from sound practice in such matters might result in discipline to fit the needs of the situation. If all hospital staffs in a given community incorporated this principle in their organizational structures, thus subjecting all doctors in that community to the same disciplines in respect to hospital utilization, the problem of "medical shopping" in search of the doctor who will do the patient's bidding instead of satisfying his own medical conscience might be minimized.

Blue Cross interests would be protected. The shortage of hospital beds might be reduced. The work of the hospital might be more efficient Personnel shortages might not be so obvious, and better hospital and medical care at lower cost would be inevitable.

Planning and Organizing for

CARE OF THE CHRONIC PATIENT

Increasingly, chronic disease is recognized as the nation's No. 1 health problem. Expansion of the Hill-Burton program this year makes special funds available for construction of chronic disease hospitals, nursing homes, rehabilitation centers and diagnostic facilities — all demanding integration with the general hospital if they are to be most useful. The nature and function of these facilities are described in the features on the following pages:

The Job of the Community
Surgeon General Leonard A. Scheele

Home for Aged and Chronically Ill
Kingsbridge Home, The Bronx

Hospital Unit for the Long-Term Patient
Dean Roberts, M.D.

Making the Pattern Fit the Problem
St. Vincent's Hospital, Omaha, Neb.

Rehabilitation Unit for the General Hospital
St. Francis Hospital, Peoria, Ill.

Flexible Nursing Unit for Chronic Patients
Home for Incurables, Chicago

Diagnostic Facility for Outpatients
Laurens County Health Center, N.C.

Plan for a Modern Nursing Home
Washington State Health Department

The Job of the Community

LEONARD A. SCHEELE, M.D.*
Surgeon General, Public Health Service
Department of Health, Education and Welfare

THERE has been a continuous shift in the nature of our national and community health problems. Therefore, we must plan specifically and creatively for the kinds of community facilities we need now and shall need in the years ahead as strongholds from which we can most effectively attack the major causes of illness and invalidism in our aging population. We are all aware that these major causes are chronic disease, mental illness, congenital defects, and accidental injuries. Estimates of the numbers of persons afflicted with these disabling conditions have been widely publicized. These problems do not, however, exist as enormous masses of figures. They exist as the human suffering of individuals. They exist as the economic struggle of families to meet the costs of suffering. They exist as the community's efforts to provide the essential health services. And they exist in reality in yet another way: as research

*Condensed from an address presented at the 1954 annual meeting of the National Association of Methodist Hospitals and Homes.

problems for the medical scientist. The medical scientist perceives these health problems in quite different terms of reference than the afflicted individual, the family, and the community. Although he may have a general humanitarian motivation for his research, his primary aim is to get the correct answers to specific biological questions. It is not his job—nor should we expect him—to mediate the impact of medical discovery on society. That is the job of the community. Up to the present time, the community in general has not always done the best possible job of evaluating the potential effects of medical discoveries and in planning for their most effective application.

This is particularly true in our planning for health and medical facilities. Hospitals and medically related institutions must be planned, designed, constructed, equipped, staffed and located so as to carry out their broadening missions both today and tomorrow.

They must be prepared to deal with the individually varied and chronologically changing physical and mental problems of the aged. And these problems must be viewed in the light of medicine's increasing ability to extend the life span, and of society's aim to keep the later years of life productive.

They must be prepared to deal with increasing numbers of chronically ill patients in all age groups, who require a wide range of services, varying from high-cost bed care in general hospitals to relatively low-cost convalescent or domiciliary care, and ambulatory care.

They must be prepared to utilize fully the rapidly growing armament of new technics and equipment for the management of all types of illness, acute and chronic, and for restoration of the handicapped.

Obviously, no single, all-purpose institution can meet all these needs. We need a network of general hospitals, special hospitals, clinics for ambulatory patients, nursing and convalescent homes, rehabilitation centers, and home care programs—all working together to outflank the major health problems of today and tomorrow. The community must now reassess its plans for the provision of facilities and for the organization of services so that present and oncoming medical advances may have their maximum life saving, health restoring impact on all the people.

In that task, no element of the community is quite so important, quite so much the obvious leader, as is the voluntary institution. The community looks to its voluntary institutions—no less than to its official agencies—for leadership, for expert advice, and for the provision of facilities and services. The voluntary institution, in turn, should be able to look to the community for adequate financial support and for cooperation in the effective planning and coordination of services. I am convinced that flexibility in determining needs is the only basis on which our communities and their voluntary agencies can plan effectively. Even with a flexible pattern, it will not be easy, for it is often hard to convince people that a "new look" at a problem will not rob them of some preconceived and cherished idea.

In general, we have emphasized beds for patients rather than adequate provisions for the walking patient. I hope that in future planning our communities will emphasize those types of facilities whose primary purpose will

Home for Aged and Chronically Ill

Kingsbridge House, Bronx, N. Y.

KINGSBRIDGE HOUSE, the 400 bed Bronx division of the Home for Aged and Infirm Hebrews of New York, was designed originally to provide quarters for 50 per cent ambulatory and 50 per cent chronically ill patients. However, Joseph Douglas Weiss, architect for the project, has arranged many of the ambulatory areas so that they can easily be converted into nursing home facilities.

This decision was in accord with the view expressed by Richman Proskauer, president of the Home for Aged and Infirm Hebrews. Discussing the present-day trends in the care of the aged, Mr. Proskauer stated:

"There is every reason why these individuals should continue living independ-

Exterior of Kingsbridge House, the 400 bed Bronx division of the Home for Aged and Infirm Hebrews, New York City. This photograph shows the recently constructed main building, which adjoins the old main building seen at the rear.

Architect's model of the Kingsbridge House group of buildings that will ultimately serve about 1000 people. This model, showing rebuilt and existing structures, is the starting basis for development of the available plot of land.

be to keep all of the patients on their feet some of the time, and some of the patients on their feet all of the time. A diagnostic and therapeutic center, a rehabilitation center, physically and organizationally related to one or more of our fine general hospitals, would afford a splendid opportunity to apply the most recent advances in preventive and restorative medicine to the problems of chronic disease and aging.

We should, of course—we must—press forward in providing additional hospital facilities for patients with chronic disease. Numerous voluntary agencies and institutions have been urging increased attention to the needs of the long-term patient.

The Commission on Chronic Illness has already sponsored some significant studies bearing on the topic. For example, in 1950, the commission analyzed reports from about 2600 general hospitals of 50 or more bed capacity, and found that only 3 per cent of these had special facilities or arrangements for the care of long-term patients. The commission was unable to learn how many such patients are cared for in general hospitals. Yet it has been estimated that from one-fourth to one-half of the days of hospitalization in our general hospitals are devoted to patients with chronic diseases, excluding tuberculosis and mental illness.

As a unit of a general hospital affiliated with other institutions, the chronic disease hospital can be the bridge between acute care and long-term care, as well as the bridge to complete care for patients in small cities and rural areas. The chronic disease hospital offers important economic advantages also. At current prices, the cost of construction and equipment for a separate chronic disease hospital can be estimated at about $13,000 per bed, as contrasted with about $16,000 per bed to construct a new general hospital. When the chronic disease facility is constructed as a unit of a general hospital and central services are provided by the parent institution, the costs are even lower per chronic disease bed. Major savings in operating costs and in charges to the patient also can be expected in chronic disease facilities.

Care of the chronically ill in nursing homes has been a seller's market with rapidly increasing consumer demands since 1930. The reasons are obvious. The patients in nursing homes often are very old people—one in five being over 85 years of age. In some areas half of them have been in a nursing home for more than one year. This means that many of these sick old people have outlived their immediate families; that remaining relatives or friends cannot take care of them at home. Neither relatives, friends, the old people themselves, nor the community can possibly afford the price of caring for them in general or even chronic disease hospitals in most cases. Forty per cent of the patients are bedfast and 50 per cent can barely walk to the bathroom, the dining room, or out into the porch or sun parlor.

At the present time, we do not have precise estimates of the full need for nursing home facilities. Nursing and convalescent homes are essential elements in the nation's health and medical facilities plant. Only within recent years, however, have all of the states brought these institutions under a pro-

(*Continued on Page 68*)

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ently in the community. . . . Today, with full recognition of the public need, the number of ambulatory patients [admitted to Kingsbridge] is being rapidly reduced, with emphasis on admission for the sick applicant."

Kingsbridge House consists of a group of 10 buildings originally used for infants' care and completely rebuilt inside for its new function, and a group of new buildings. The two groups are completely integrated into a smoothly operating unit.

The group of altered buildings houses (1) a nurses' residence; (2) single and double rooms and dayrooms for ambulatory residents; (3) occupational therapy; (4) power plant, and (5) laundry.

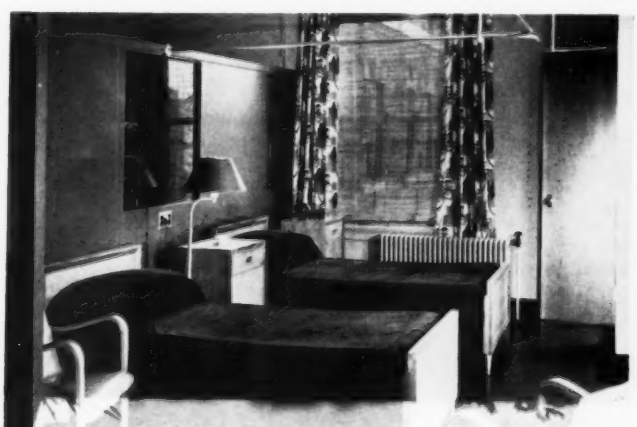
The heart of the institution, according to the architect, comprises the main old building which has had added to it a new dormitory type of structure and a recreation building.

The main entrance lobby houses the reception office and on this first floor are concentrated the most heavily used facilities, such as general offices, library, accounting office, medical department, chapel, beauty parlor, barber shop, central kitchen and recreation room.

The top floor of the new building is especially designed for private paying patients. On this floor are a number of rooms with private baths. It is expected that "private pavilions" will be as common in old age institutions as they are now in hospitals.

Above: The recreation room is equipped with a stage and complete moving picture projection service. Below: The dining area, located on the floor above the main kitchen, is pleasant and well lighted — with windows on three sides.

Below: A semiprivate room. All rooms are equipped with clothes closets for each person, wash basins, modern direct and indirect illumination, and nurses' call system next to each bed. Decoration is cheerful and quite uninstitutional.



gram of state licensure. Even now there is no requirement in the majority of states that the patients in nursing homes be under medical supervision.

As the true value of medically related nursing homes in improving our care of the chronically ill and the infirm becomes fully apparent to our states and communities, I am sure that we will see progressive improvement of services in these institutions, and a substantial increase in the supply of such facilities. As the economic burden of illness in our aging population increases, it becomes more and more important that we take full advantage of the economies possible in the construction and operation of nursing and convalescent homes as a means of utilizing more effectively the beds in general and chronic disease hospitals.

CARE OF THE CHRONIC PATIENT

Hospital Unit for the Long-Term Patient

DEAN W. ROBERTS, M.D.
Director, Commission on Chronic Illness, Baltimore

THE needs of the long-term patient are more complicated than those of the acutely sick person. He may have a multiplicity of serious diseases. He is in need of intensive diagnostic study and evaluation at the time of initial hospitalization, and this must be thorough, extensive and painstaking.

"Because of the nature of serious chronic disease requiring hospital or institutional care, the patient's total adjustment to life may be seriously disturbed. He needs, in addition to definitive medical care, the kinds of services which will restore his morale and help him adjust to an altered life situation. Accordingly, extensive services are required to provide for the medical, nursing, emotional, spiritual, economic, social and rehabilitative aspects of his care.

"Restoration of the chronically ill person to community usefulness may be rapid, slow, delayed or subject to repeated relapse. Many chronically ill patients are burdened with permanently impaired health so that their level of activity must be modified considerably. The patient's general condition is rarely static and is subject to continual change requiring extensive health and institutional resources in order to meet his needs satisfactorily."*

The broad range of institutional services required for long-term patients has, at times, created confusion and problems. The general hospital, with its technical and scientific orientation, does not want to use its facilities for patients whose primary requirement is domiciliary care—yet the chronically ill patient at times needs the most expert and professional care a hospital can offer.

Long-term or chronically ill patients, of course, have episodes of acute illness or exacerbations of their chronic conditions, which require the facilities of the general hospital, just like any other patient. Over and above this ordinary need for hospital services, the chronically ill patient requiring prolonged institutional care has other specific requirements which are probably best met by the general hospital. It is widely agreed that patients should not be admitted to nursing homes or homes for the aged until they have had a meticulously careful diagnostic evaluation leading to a definitive diagnosis, an appraisal of the potentialities for rehabilitation, and the services required for treatment. Unless such procedures are regularly carried out, we will continue to see in nursing homes and similar facilities progressive deterioration of patients who are capable of dramatic improvement in hospitals geared in plant, staff and philosophy to their rehabilitation.

Not only do long-term patients require a broad range of services but also coordination of these services is needed because of the importance of providing the proper service at the proper time. A person's chronic illness is characterized not only by its length but also by the changes which occur in his condition and which dictate changes in his care and treatment.

In planning services for the chronically ill, therefore, we must keep paramount at all times the requirement that all the services needed are tied in together sufficiently closely so that they are readily available to the patient when they are needed. To some, such close coordination can be achieved only if all services are provided by a single institution. To others, close administrative relationship of separate physical facilities will do the trick.

At some point in their illness, most long-term patients need care that is at a hospital level. They are:

1. Persons requiring short-term care for treatment of an acute episode of a chronic illness, or for surgery, *e.g.* the patient with diabetes, the patient with early cancer or tuberculosis requiring surgery, or the patient with mental disease needing short-term psychiatric care for diagnosis and development of a treatment plan.

2. Patients who require long-term definitive management beyond what the usual convalescent facility is able to provide; these patients may or may not have a favorable prognosis; examples are the severely decompensated cardiac, the long-term cancer, and the cirrhotic patients.

(*Continued on Page* 150)

*From the report of the National Conference on Care of the Long-Term Patient, held under the auspices of the Commission on Chronic Illness, Chicago, 1954.

St. Vincent's Home for the Aged, Omaha, Neb., operated by the Sisters of Mercy. Residents have an uninterrupted view in almost all directions from any floor in the institution, owing to the elevation of the site.

THE MODERN HOSPITAL OF THE MONTH

CARE OF THE CHRONIC PATIENT

They Made the Pattern Fit the Problem

STEELE, SANDHAM and STEELE
Architects, Omaha, Neb.

ST. VINCENT'S Home for the Aged, Omaha, Neb., is operated by the Sisters of Mercy who also operate St. Catherine's Hospital in Omaha. Sponsored by the Most Rev. Gerald T. Bergan, S.T.D., archbishop of Omaha, the home draws its guests from every parish in the Omaha diocese. First guests were admitted in July 1953.

The home is situated in the northern section of the city and consists of approximately two square blocks on fairly high ground. The site was previously undeveloped but is surrounded by a partially developed residential district. The grounds overlook, and are within walking distance of, one of the city's better parks. The elevation of the site permits an almost uninterrupted view in all directions from any floor of the building.

Before the structure was designed, several months were spent by the architects in studying the problem of caring for the aged; all available sources were tapped, and several private and public institutions were visited.

The architects found that only in recent years has any advanced thinking been undertaken in this field, and came to the conclusion that the design problem did not fit into any established pattern. Rather, the problem revolved about the physical and spiritual care of the guests, and the need to operate the plant efficiently and economically, while still evolving a plan which would not be classed as

OUTLINE OF COSTS

Total Costs (including Groups I and II equipment and landscaping)	**$2,123,624.83**
Total area	**141,500 sq. ft.**
Total cubage	**1,636,400 cu. ft.**
Beds	**228**
Cost per bed	**$9340.00**
Sq. ft. per bed	**618**
Cost per sq. ft.	**$15.00**
Cu. ft. per bed	**7160**
Cost per cu. ft.	**$1.30**

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects, and the state officials. A similar award will be made by The Modern Hospital each month.

Closeup of the main entrance of the home, showing the sweeping glass area on the second floor. Exterior walls are constructed of 4 inch brick.

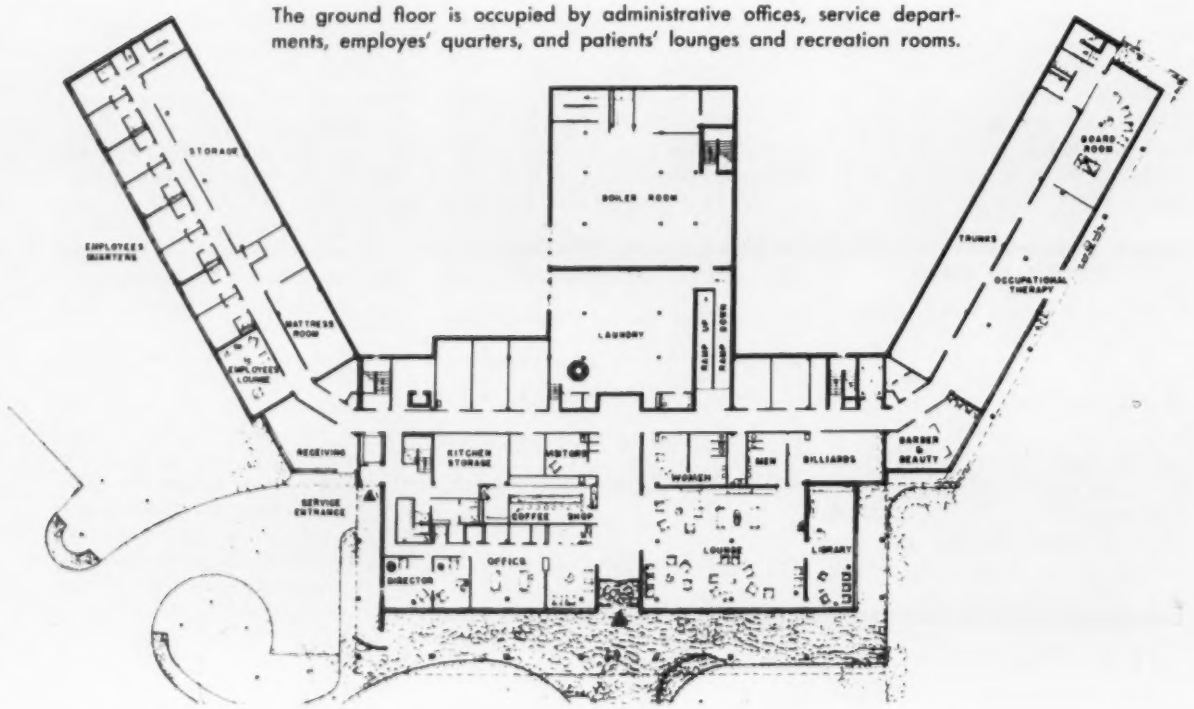
an "institution." It was intended that the home should be "self-contained" in function so that the need for making use of outside services would be as limited as possible.

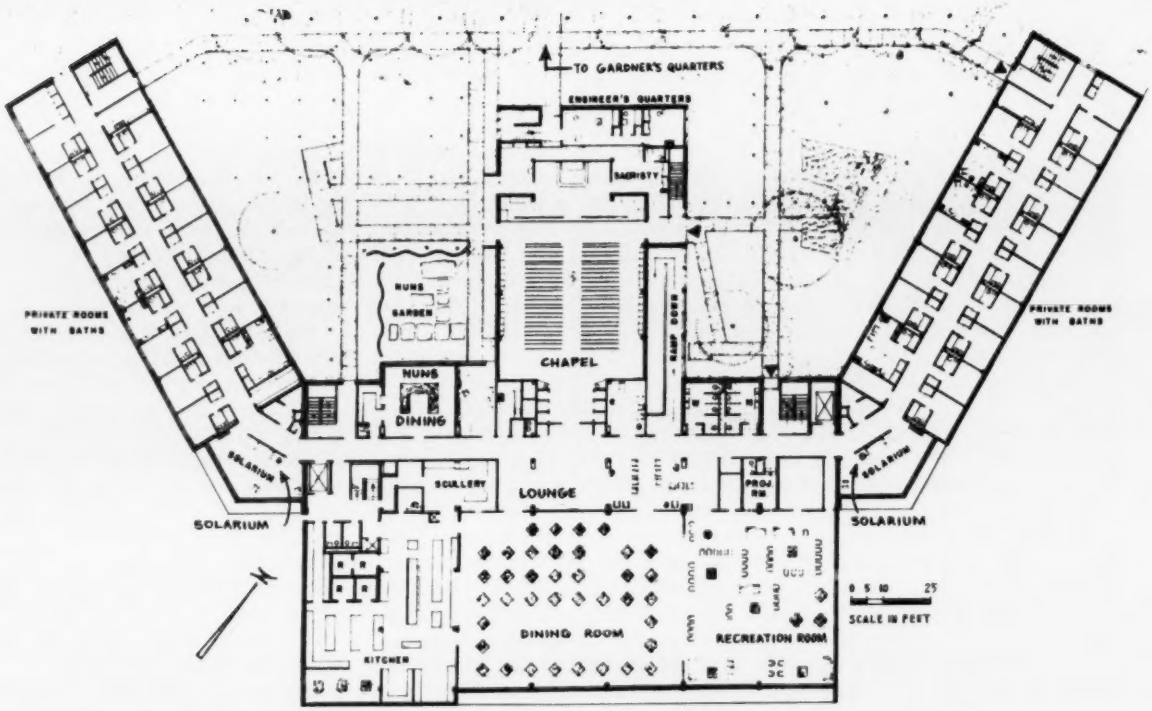
It was planned that the care provided for the chronically ill would be equivalent to that normally found in a hospital, although the home does not provide for "hospital" cases, as such. There is no surgery or x-ray department.

The building will house approximately 228 guests (including six priests), of whom approximately 54 persons will be classified as chronically ill, and probably nonambulatory. The

(*Continued on Page 72*)

The ground floor is occupied by administrative offices, service departments, employes' quarters, and patients' lounges and recreation rooms.





Top of page: Plan of the first floor on which the main kitchen and dining hall are centrally located. Also on this floor is the chapel, which is two stories high. Above, left: View of patients' rooms. Above, right: The view from one of the solariums. Below, right: If patients get tired of looking out the windows, they can look at the world as depicted on this map in the big recreation room.

(*Continued From Page* 70)
operating staff, as anticipated, consists of approximately 50 full-time personnel, including nuns. Living quarters are provided for nuns, engineers, nurses, orderlies, chaplain, resident doctor or intern, and eight additional staff members. The work of the staff is supplemented by the efforts of some of the more able-bodied guests and a few outsiders and volunteers.

The structure is a six-story fireproof building built in spread-eagle shape, with the front face of the building (wings are to the rear) facing the southeast and overlooking the park. Heating is supplied by hot water system, supplemented by conditioned air introduced under pressure on each floor. Boilers are operated by gas or oil.

The grounds surrounding the building are landscaped to provide a pleasant atmosphere, and while some of the grades appear somewhat steep, walkways are wound around to provide an easy grade. The main service and entrance drive is brought in from a side street rather than from the heavily trafficked street in front of the building. Off-street parking is provided. Outdoor recreation facilities are limited to walking, gardening, croquet and horse-shoes.

The ground floor, at grade, is devoted to administrative offices, a large semipublic lounge, billiard room, library, public toilets, morgue, utility spaces, kitchen storage, trunk storage, general storage, service entrance for supplies of all types, and one wing partially devoted to space for a program of occupational therapy. A coffee shop is provided near the lounge to provide lunches for visitors, who will not be encouraged to use the main dining room. Located here also is a candy, tobacco and magazine stand. The main lounge is intended for visiting and reading purposes.

The center rear wing houses the central boiler plant and laundry. The portion of the building housing the administrative, lounging, dining, recreation and kitchen facilities is a two-story block projecting beyond the front face of the main structure.

To handle traffic within the building there are two strategically located passenger elevators, one of which is also used for freight and supply transportation. In addition, there are four enclosed stair towers leading to all floors and exiting to grade at grade levels.

From the ground floor to the first floor is the one and only ramp in the building—to accommodate heavy traffic between these two floors. It is felt that traffic to upper floors should be by elevator only.

On the first floor, the main kitchen and dining hall are centrally located. Adjacent to the dining hall is a recreation room. Also adjacent to the area is the chapel, designed to take care of ambulatory guests and staff. This chapel is two stories in height, located above the laundry and boiler room, and has an accommodation balcony on the second floor especially for wheel chair guests.

The main dining room is designed to seat persons at tables of four to be served by helpers direct from an opening to the kitchen, with portions served on plates rather than "home style."

It is planned to use the recreation room for card games and regular movies, and for special occasions the space can be opened into the dining room by the simple operation of folding partitions.

The two wings of the first floor are devoted to private rooms, with baths, one-half for men, and one-half for women, the guests being those who can afford to pay for the privilege of a private bath.

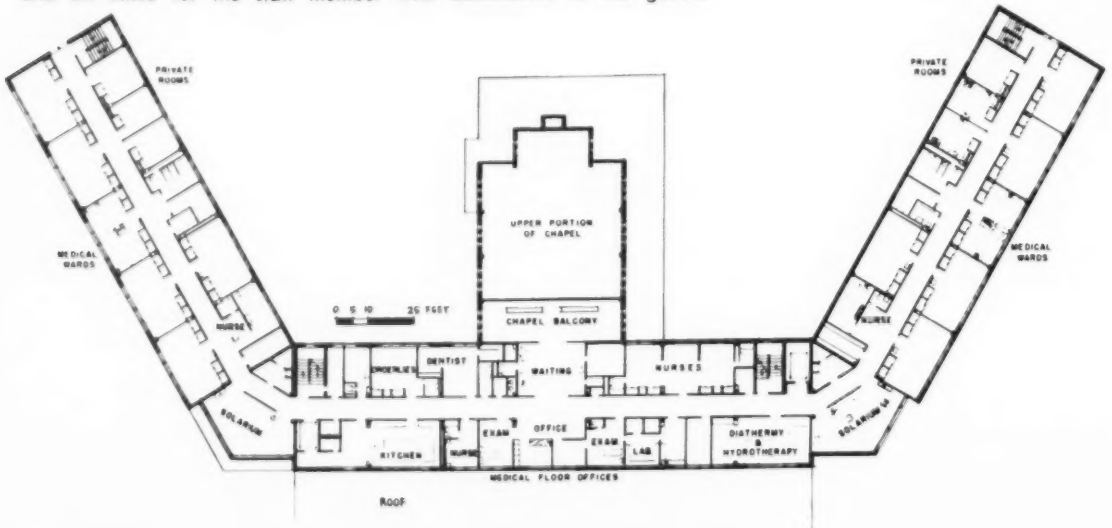
The second floor is designed for the use of the chronically ill, and accommodates the majority of them in four-bed wards. It was felt that four-bed wards permit a more sociable atmosphere for sick persons and ease the nursing problem. However, provisions are made for subdivision of these spaces when privacy is desired. In addition, in each wing there are at least two private rooms for isolation or special cases which demand privacy.

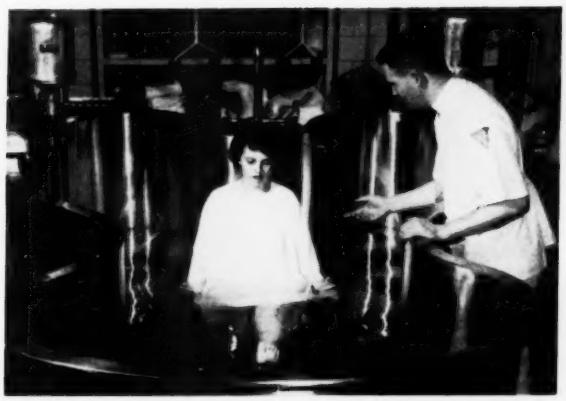
The central portion of the building houses the functional elements needed in the care of these guests, including serving kitchen directly above the main kitchen, doctor's offices, examination rooms, laboratory, physical therapy room, diathermy rooms, dentist's office, nurses' and orderlies' rooms, wheel chair room and linen room.

The upper floors are occupied by the ambulatory guests, except for the space reserved for the nuns' cloister; six suites, each comprising a study, bedroom and private bath, for aged priests, and suites for the doctor and the chaplain.

Special facilities common to all floors include solariums designed for year-round use, snack bars, equipped with refrigerator, hot plate and sink, for between-meal refreshments for guests; clothes chutes, and incinerator outlets. There is a small office on each floor for the staff member who administers to the guests.

Plan of the second floor. Patients' rooms are located in the wings of the building, while the main section contains examining and treatment areas and an office for the staff member who administers to the guests.





The buoyant effect of water helps in the exercise of muscles.

CARE OF THE CHRONIC PATIENT

Rehabilitation Unit for the General Hospital

H. WORLEY KENDELL, M.D., JOSEPH N. SCHAEFFER, M.D., AND HUGH J. McMENAMIN, M.D.

ESTABLISHMENT of physical medicine and rehabilitation as a medical specialty carries with it the implication that it is now the responsibility of the hospital and the medical profession to look beyond the date of hospital discharge to the problems the patient will face in his job, in his family, and in society. If federal legislation designed to stimulate hospital and health center construction is based on the idea that such services are desirable everywhere in the nation, then, as a part of this over-all expansion, the growing needs of physical medicine and rehabilitation should be considered as an integral part of the total project.

For most hospital patients, post-discharge problems are relatively simple or even nonexistent, as in acute illness or trauma where the person recovers rapidly and returns to his regular occupation after a brief convalescence. It hardly seems necessary to mention that this is not always true. Sometimes, there is residual disability, bringing with it problems far beyond the ability of either the patient or his family to solve without outside help.

In most communities in the nation, integrated services of this nature, at a professionally competent level, are either wholly lacking or of a highly questionable adequacy. This remains true, despite some progress of recent years in establishing teaching and research rehabilitation centers at some of the great universities and in larger cities.

During recent years, much has been written about the basic philosophy of rehabilitation. Indeed, many of the phrases have reached the status of the cliché. The various types of rehabilitation centers have been defined and redefined, classified and reclassified. Although a general repetition of this material is unnecessary, for the purposes of this paper, one distinction should be made. Any consideration of a general hospital as the parent facility to a rehabilitation center must first point out the essential difference between such an arrangement and the self-contained unit having its own beds, operated from top to bottom by and for the physical medicine and rehabilitation program. An understanding of this basic difference, which will become clearer as we proceed, may help to avoid certain administrative difficulties prejudicial to the success of the program.

In a previous contribution to this journal* I pointed out that, in discussing needed community facilities, it is unsafe to generalize; communities differ in size as well as extent and character of available facilities. Right after World War II, the idea of separate rehabilitation centers dominated our thinking and, in the larger cities, institutions of that character have been set up. Beyond question, these centers have demonstrated the practical basis of the underlying idea of rehabilitation. However, the fact remains that extension of such services to the smaller communities and their trade areas requires (a) a flexible approach and (b) a greater stress on existing facilities. I added then that an approach of this kind inevitably leads us to a consideration of the community hospital as a starting point for a community civilian rehabilitation center.

Here, as I have indicated, the situation is not the same as it is in the separate center. In order for the service to succeed, the administrator and staff of the hospital must be acutely aware, both of its existence and its need: that the end point of the management of a patient involves more than the healing of a pathological process. The optimal situation for the success of the physical medicine and rehabilitation program lies in the initial conviction on the part of the administrator that the service is necessary. This conviction must be conveyed to his board and to the staff, so that all other services become aware of it—particularly the nursing service.

As a leading service in the hospital, the nursing service holds, or very nearly so, the fate of the program in its hands. Inclusion of the basic principles of physical medicine and rehabilitation in the training program is the most effective way of infusing, through every

The authors are, respectively, medical director, Institute of Physical Medicine Rehabilitation, Peoria, Ill., associate medical director, and resident fellow, U.S. Public Health Service.

*Kendell, H. Worley: Rehabilitation Unit. Mod. Hosp. **78**:67 (March) 1952.

A typical four-bed rehabilitation service ward. Note overhead frames for attaching special apparatus. Beds may be adjusted in height for the convenience of the patients.

Carefully selected and supervised exercises gradually strengthen weakened muscles. These are special tables equipped with weights, pulleys and assistive devices.

other department, the ultimate aim of a patient's management: a happy physical, social and economic adjustment once he is discharged. In brief, the administrator must set up a physical medicine and rehabilitation program compatible with the nursing service to be given and then institute an instructional program to fit the need.

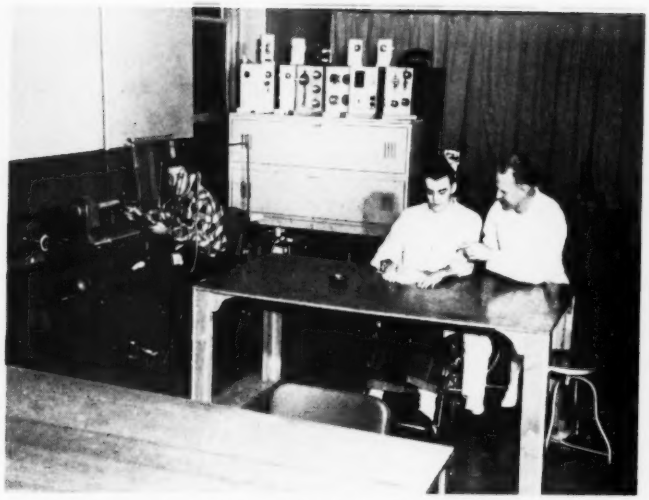
For the past several years, I have been fortunate in having the opportunity to acquire firsthand experience in the operation of a central rehabilitation facility in an industrial community of about 200,000 people. What I have learned reinforces the impression as I have stated it.

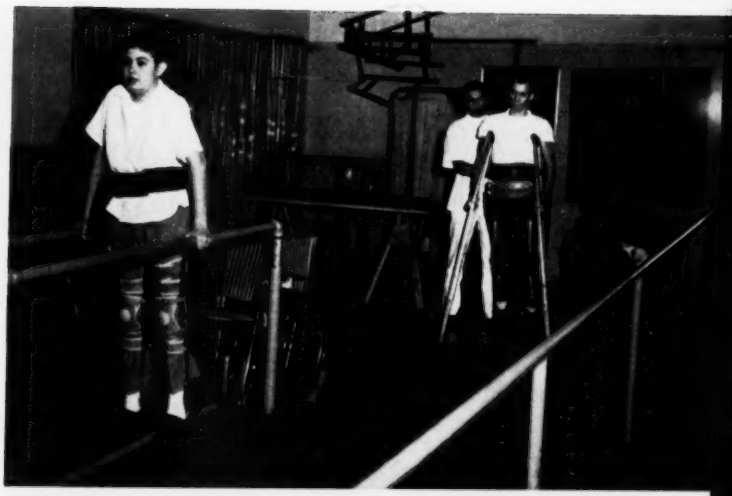
The Peoria Institute of Physical Medicine and Rehabilitation emerged from a realization of community needs. Both lay and medical leaders in this community had been acutely conscious for a long time of the need for bringing modern medical and restorative technics into effective play for returning disabled people to useful and happy lives. The Peoria Plan for Human Rehabilitation, which, during the war, was a successful community project for selective job placement of veterans, demonstrates that the basic idea was established before it found expression in the buildings and equipment, some of which are shown in the accompanying photographs. The preexistence of this idea placed the emphasis where it belonged: on the fact that actual rehabilitation is something which takes place in a community, rather than in a building; that, while the physical plant furnishes an important central point for diagnosis, treatment, psychosocial and economic guidance, the actual channels of the rehabilitation process extend to all the facets of community life, *i.e.* the family, the school, the job, the church, the fraternal organization, and the social club.

When the directors of the Forest Park Foundation made funds available to establish the institute in connection with St. Francis Hospital, they were acutely aware that rehabilitation is a complex thing that involves more than a single building. This basic concept has been a liberating influence on expansion and adaptability. Recently, the Methodist Hospital division of the Institute of Physical Medicine and Rehabilitation opened its doors, and its operations are wholly integrated with the St. Francis branch.

Large picture: A polio patient measures his ability to exhale without having air escape through his nose. Inset: The patient relearns to place his lips to form sounds.

The little girl in these pictures is being taught the skills necessary to daily living. Here she practices getting on and off buses despite the handicap of wearing braces.





Occupational therapy deals chiefly with hand skills. At the institute, these skills frequently are taught to help the patient learn a new job if he cannot return to his old one.

The new Methodist Hospital unit makes available an additional 8000 square feet of air-conditioned floor space. This will assist materially in accommodating the flow of patients and in expanding inpatient service. The additional space will also make possible future expansion of diagnostic and treatment facilities already under consideration.

Pursuant to the fundamental idea that all existing agencies and facilities should be used and not duplicated, the division of vocational rehabilitation of the state of Illinois provides the services of vocational testing, counseling and job placement. Closely integrated with the institute have been the established services of the division of services for crippled children, which in this state is administered by the University of Illinois. Also, the division of special education of the state board of education, as well as the county board of education, work closely with the institute.

Cooperation with voluntary agencies is an integral activity of the institute. Contact is maintained with many of the Illinois downstate chapters of the National Foundation for Infantile Paralysis. The institute has made available the physical space for a cardiac work classification unit, sponsored by the Greater Peoria Heart Association, local hospitals, and county medical society. A preschool program for cerebral palsy has been set up through an organization of mothers of these children motivated through the local crippled children's coordinating committee. The group takes full responsibility for this nursing school program.

The institute enjoys excellent relations at the professional level for a number of reasons. Among these is

Above: A patient with full-length braces is being taught to walk with crutches. Right: Patients are taking progressive resistance exercises preparatory to crutch training.

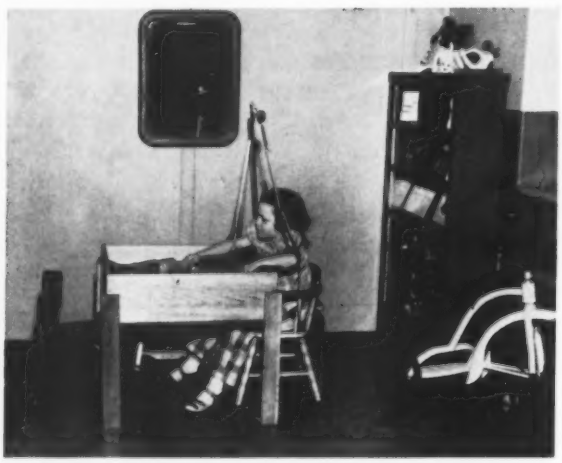
Electricity is used not only to test muscles, as is being done here, but also to transmit impulses that will exercise muscles whose nerve supply has been temporarily interrupted by injury.

A typical corridor in the Forest Park Home Division of St. Francis Hospital where patients referred by the institute are housed.

the fact that the referring practitioner or specialist does not lose contact with his patient. The Institute of Physical Medicine and Rehabilitation starts and continues as a consultant. During the period of prescribed treatment, continuous reports on the patient's progress are furnished to the referring physician in whose hands remains the ultimate responsibility for the total management of the patient.

This brief review of the plant and program of the Peoria Institute of Physical Medicine and Rehabilitation is presented as a basis for the suggestion that effective adaptations of such a plan can be projected by hospitals in other communities, with modifications which will strike a balance between needs and resources. If the modern concept of the function of the hospital in the community is to be fulfilled, it is difficult to see how this consideration can be overlooked when new or expanded hospital facilities or health centers are being planned. No active administrator is unaware of the difficulties involved, among which personnel shortages are not the least. Nevertheless, we must look forward, hoping that the very pressure of the need will stimulate fulfillment.

A sit-down shower, with multiple shower heads that can be adjusted in any direction. A swivel stool with arm and back rests permits the paralyzed patient to bathe himself.



Where arm muscles are too weak to support their own weight, overhead slings attached to the chair permit mild exercise through play, eating or other activities.

This patient is receiving diathermy, or deep heating of tissues by means of high-frequency radio waves, to relieve pain and hasten recovery.

This is not to say that creation of a rehabilitation center should be necessary or desirable at every crossroad. The Institute of Physical Medicine and Rehabilitation of Peoria draws its case load from a radius of 100 miles. If a truly flexible attitude is maintained toward the provision of integrated rehabilitation services, a considerable area could be served by the strategic location of such a center within a given trade area. In the more sparsely populated areas, it seems wholly likely that the hospital could supply enough inpatient beds to accommodate patients living remote from the center, at least for a minimum period of initial treatment and instruction to lay the basis for continuing the treatment at home. Outpatients might constitute the greater part of the case load, which indeed is true of many of the centers in big cities today.

The representatives of the vocational rehabilitation service, the crippled children's service, and other official and voluntary agencies could have regular days on which they would fulfill appointments. If a qualified physiatrist is not available to direct the medical phases of the program, efforts might be made to place it in charge of a physician who has shown a special interest in physical medicine and rehabilitation problems. In that event, a specialist in physical medicine might be brought in on a consulting basis from some other area at stated intervals.

While such an arrangement might have its drawbacks and present some difficult problems, there is enough precedent to indicate that it would be basically workable. Not only that, but that its functioning would improve with use, particularly as the physicians of the area watched the program in action, becoming aware of the value of physical medicine technics in speeding recovery, and removing from the shoulders of the busy practitioner or specialist the time consuming and troublesome problems of helping his patients to a happy adjustment, physically, at home and in his job.

Flexible Nursing Unit for Chronic Patients

THESE sketches present an idea for patient accommodations prepared in connection with the development of an integrated program of care for the chronically ill, permanently disabled and infirm aged for the Chicago Home for Incurables.*

The plan (right) shows a basic module using an off-center corridor with rooms on one side accommodating either two or three beds and rooms on the other side providing one or two beds. The module is 26 by 43 feet, not including outside walls, and provides four rooms with a toilet between each pair of rooms. The larger rooms are 12 feet 6 inches by 20 feet. The smaller rooms are 12 feet 6 inches by 14 feet. This area includes the toilet space which is large enough to permit access to a wheel chair patient. The corridors are 8 feet.

The rooms would be used with the larger number of beds for strictly bedfast patients. This arrangement provides 3 feet between beds and an aisle 3 feet 5 inches wide. Semipermanent lockers 25 inches deep are installed along the one wall beyond the toilet space and a lavatory. A dresser is included in the three-bed rooms.

The rooms would be used with the smaller number of beds for patients who are able to be out of bed in a chair or wheel chair part of the time, or for those who require active medical treatment involving oxygen therapy or similar procedures requiring more space. In this case the lockers would be removed from the toilet wall and installed along the corridor wall. This change will permit the inclusion of comfortable lounge chairs and a desk and will emphasize the spaciousness of the rooms.

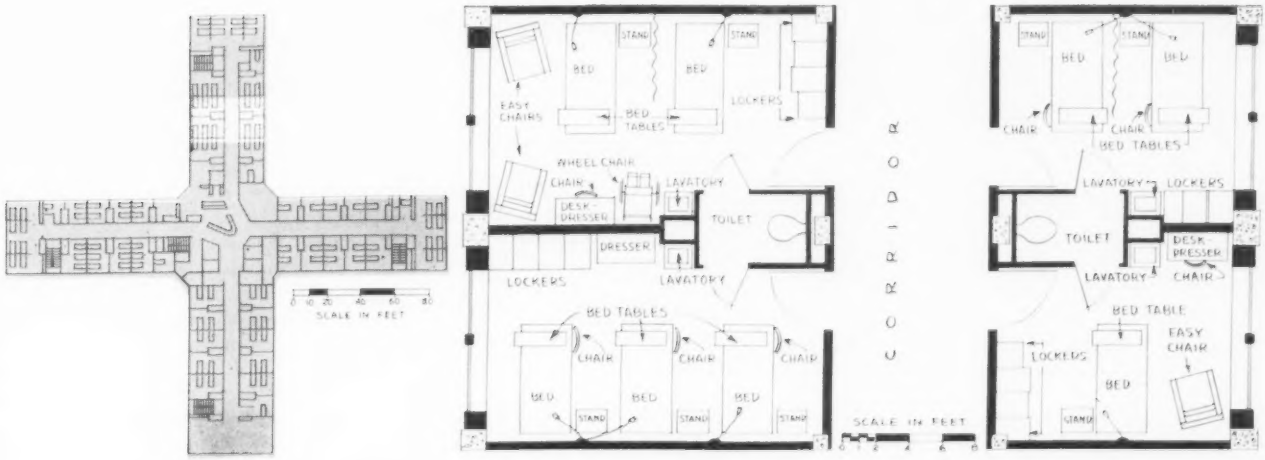
The allocation of space provides a minimum of 72.5 square feet for strictly bedfast patients and a maximum of 145 square feet for semiambulatory patients. While it is not intended that the changeover from one type of room to another would be made on a daily basis, the semipermanent lockers would be installed in a manner that would require a minimum of expense when a changeover became necessary.

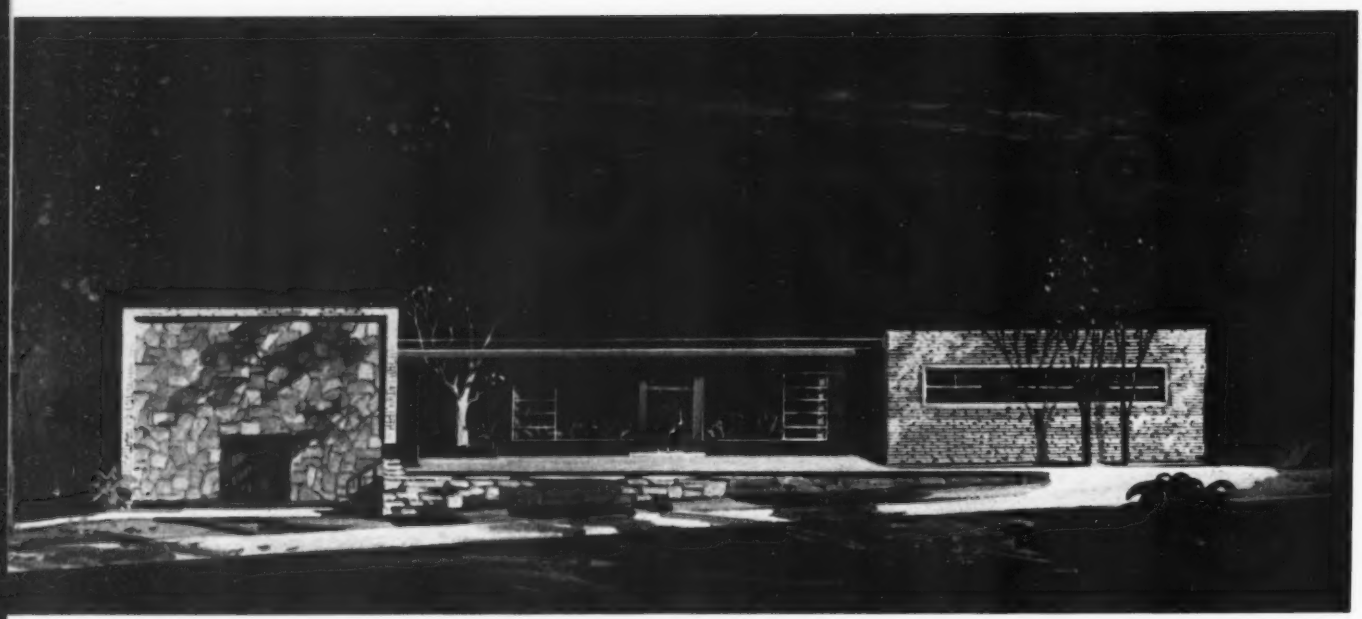
The plan (left) shows a cross arrangement with only one nursing station per floor. In addition to the central core, which is 61 by 61 feet, there are three 43 foot wings, each having three standard modules and one end module 21 by 43 feet. The fourth wing is 49 feet wide and has 20 foot rooms on both sides of the corridor. This wide module provides better accommodations for ancillary medical services on other floors and preserves the flexibility of the building so that it could be used for acute care if this ever became desirable. The end type module provides dayroom facilities or may be used as an eight-bed room.

The use of a single nursing unit accommodating as many as 100 patients assumes the adoption of team nursing procedure—with the establishment of decentralized administrative authority not related to the physical facilities. The nursing station is large and includes a clearing area, examination and treatment room, office and conference rooms, linen storage, a personnel toilet, access for patients to an adjoining room toilet and ample cupboard space. Walking distances for a nursing unit accommodating 100 patients is kept within reasonable limits. The corridor distance from the central core to the end rooms is 78 feet. Functional walking distance within the core will range from 5 to 40 feet.

*Developed by Arnold F. Emch and Arthur J. Sullivan of Booz, Allen and Hamilton, management consultants.

Left: Plan showing cross arrangement with one nursing station per floor.
Right: Plan of the basic module in which an off-center corridor is used.
This plan is an enlargement of the unshaded portion of plan at left.





Architect's rendering of Laurens County Health Center, Laurens, S.C.
Exterior is predominantly brick and glass, with accents of stone.

CARE OF THE CHRONIC PATIENT

Diagnostic Facility for Outpatients

LOUIS M. WOLFF
Lyles, Bissett, Carlisle & Wolff
Architects-Engineers, Columbia, S.C.

A CHEERFUL environment is created throughout Laurens County Health Center, Laurens, S. C., by walls of various colors, all harmoniously blended; wide expanses of glass that afford natural light to the rooms; full acoustical treatment that keeps noise at a minimum; even heat distribution by radiant heating coils in the floor, and an adequate ventilating system.

The building is well integrated to the sloping site, and we think there is a pleasing unity of design. The exterior is predominantly brick and glass, with accents of stone at the featured points of entrance.

The garden walls are rubble stone in greens and browns; the auditorium panel is a treatment of random ashlar Tennessee quartzite that expresses the natural graining of the stone, which varies in color from a very light tan to a deep brown. The quartzite is again recalled alongside of the main entrance, but in a more formal pattern. A stylized caduceus, wrought from iron and located on the stone wall, has a sculptural quality and symbolizes the function of the building.

The floor plan achieves the intent of the program, namely:

1. Patients have a single entrance for good control, with counter directly facing the entrance and easy access to the waiting room and public toilets.

2. The clinical facilities are well separated from the offices of the health officer and his staff. This avoids confusion in circulation and maintains a quiet working area for the staff.

3. Rear access to the staff parking area is provided for convenience.

4. There is an exterior entrance to the auditorium for public use, with an interior entrance directly to the speakers' dais from the staff wing.

5. The sloping wooded site necessitated a variation in the floor levels, and this was best accomplished by lowering the staff wing. There is little traffic between the staff wing and the clinical wing, and the steps between are not burdensome.

6. Finishes were selected for economy and to keep maintenance costs at a minimum.

The function of the building is symbolized by a stylized wrought iron caduceus located on the wall alongside the main entrance to the center.

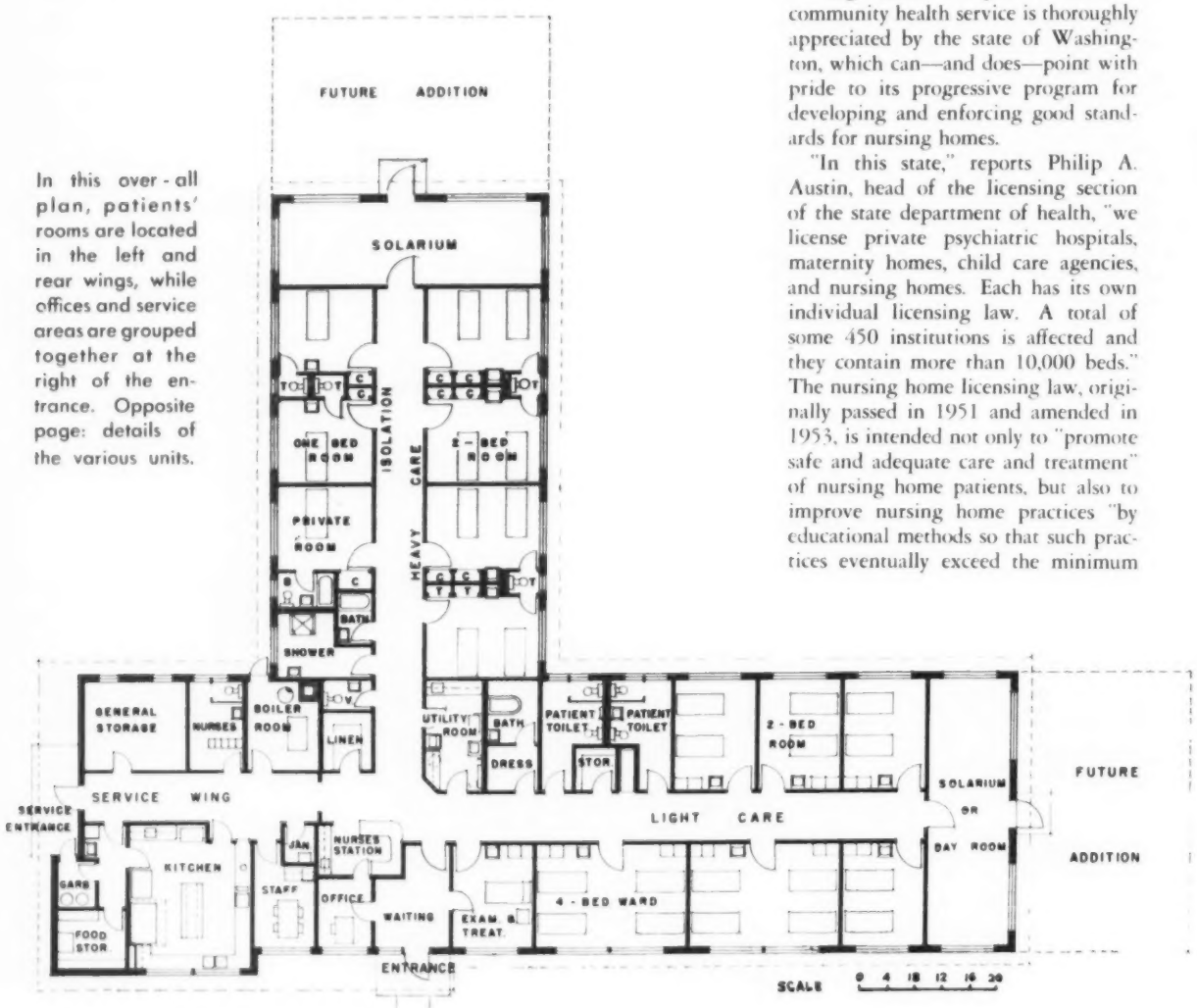
Above: Floor plan of the center. Offices of the staff members are well away from the clinical rooms, thus affording a quiet working area and eliminating cross traffic. A separate exterior entrance is provided for auditorium at left.

Right: Rear entrance to the health center, showing the use of random ashlar Tennessee quartzite which varies in color from a light tan to a deep brown.

Plan for a Modern Nursing Home

All nursing homes constructed in the state of Washington must conform with standards of good practice and planning

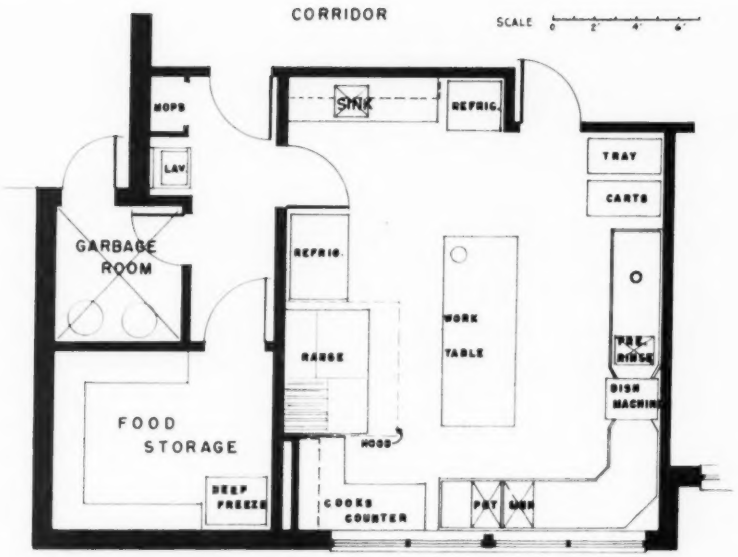
PLAN FOR A 27 BED NURSING HOME WITH ROOM FOR EXPANSION

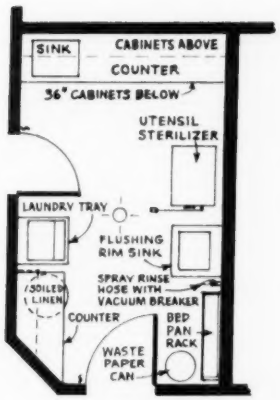


In this over-all plan, patients' rooms are located in the left and rear wings, while offices and service areas are grouped together at the right of the entrance. Opposite page: details of the various units.

THE increasing importance of nursing homes as a part of the total community health service is thoroughly appreciated by the state of Washington, which can—and does—point with pride to its progressive program for developing and enforcing good standards for nursing homes.

"In this state," reports Philip A. Austin, head of the licensing section of the state department of health, "we license private psychiatric hospitals, maternity homes, child care agencies, and nursing homes. Each has its own individual licensing law. A total of some 450 institutions is affected and they contain more than 10,000 beds." The nursing home licensing law, originally passed in 1951 and amended in 1953, is intended not only to "promote safe and adequate care and treatment" of nursing home patients, but also to improve nursing home practices "by educational methods so that such practices eventually exceed the minimum





Above, left: The kitchen plan conforms with state regulations governing the sanitary handling of food and beverages. Above right: The utility room is designed to make the greatest possible use of the small space allotted to it.

requirements of the basic law and its original standards."

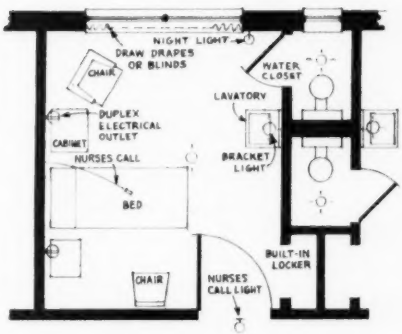
Washington's licensing laws distinguish between the general nursing homes and "specialized" homes. Special standards have been set up for the operation of specialized institutions in order to protect mentally incompetent or emotionally unstable persons who do not require intensive psychiatric treatment. These standards were promulgated, Mr. Austin explains, in the hope that they would assist in solving the problem of senile patients who, at present, "are so poorly accommodated in their own homes, in nursing homes, in hospitals, and in state mental institutions."

Last year, the state department of health took inventory of all nursing home patients in the state. Every nursing home operator was requested to fill out a questionnaire for each patient in the home, showing the patient's financial status, *i.e.* private or welfare case; the diagnosis of his illness, and the special services he required, such as feeding, assistance with baths, complete bed care, and so forth. The information revealed by these questionnaires, state officials believed, would give them a sound basis for planning for future needs.

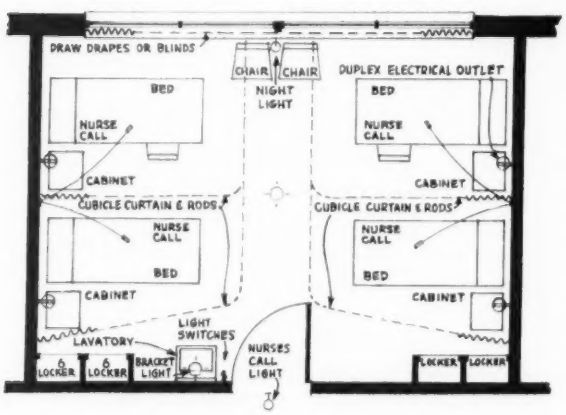
One of the provisions of the licensing act is that plans of all new buildings, additions to existing buildings, and alterations other than repair must be submitted to the state department for approval. Plans and specifications must comply with state regulations.

As part of its program of assisting nursing home operators, the licensing section of the state department of health has prepared plans for homes of various sizes, showing the proper dimensions for private and semiprivate rooms, wards, corridor widths, ceiling heights, and so forth.

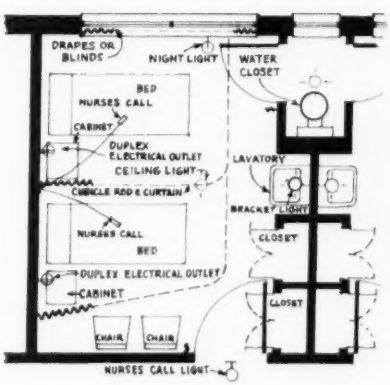
The plan and detail drawings shown on these pages are for a 27 bed home.



Above: This room can be used either for isolation, when necessary, or as a semiprivate room. It is shown set up as an isolation unit. Below: The same space adapted for use as a semiprivate room with bath. Cubicle curtains separate the beds, and each patient has his own closet.



Left: A typical four-bed ward. In this room closets are replaced by lockers for storage of patients' effects. State laws require not less than 70 square feet of usable floor space per bed, and 3 feet between beds.



Small Hospital Forum

The Recovery Room Pays Its Own Way

in terms of better patient care and public relations

LEON A. BONDI
Administrator, St. Luke's Hospital, Davenport, Iowa

WE HAD hoped to be able to include a postanesthesia recovery room in the new addition to St. Luke's Hospital, Davenport, Iowa, completed in 1952. Like many other ideas we had, it had to be left out for lack of funds, as is so often the case. We were faced with the problem of adding the maximum number of new beds for the money available and all service departments had to be added in the new unit as the old ones were out of date, inadequate and cramped.

Once the new unit was in operation and the larger facilities were being used to somewhere near their capacity, and with the usual shortage of help, it became evident that one step that would be helpful would be the establishment of a postanesthesia recovery room. We began to search for a solution to this problem. We had encouragement from medical staff members, especially those who had served with the armed forces in World War II. The director of nurses, the recovery room head nurse, one of the anesthesiologists and I made a survey of space available. We selected a four-bed ward in the old section in proximity to the operating room suite.

Our next step was to select new equipment and decide on a method of financing the cost of the equipment. The ward measurements were 22 feet wide by 14½ feet, which we estimated would be adequate in size for four postanesthesia recovery stretchers on wheels; we have since added a fifth.

We were fortunate in being able to finance the setup and so we made up the list of needed items and ordered them. We purchased four postanesthesia carts complete with I.V. standards, side rails, and 4 inch thick foam rubber pads. Other equipment included four sphygmomanometers, three oxygen regulators and humidifiers, two portable suction units, and a 1 horsepower window air conditioning unit. Other equipment such as a supply cabinet, chart desk and chair were dug out of storage and given a coat of paint. Linens, drugs and other equipment were procured from the usual sources at the hospital. Total cost was $3475, including five postanesthesia carts and the air conditioner. These two items cost $2150.

By making this investment, we have reduced the nursing hours on the surgical floors. The recovery room is staffed from 8 a.m. to 4 p.m. with a registered nurse, a student nurse and a nurse's aide. Before the advent of the recovery room we utilized the service of five nurses to give safe nursing care for the same number of patients. A nurse must remain with the patient in

Essential Equipment and Supplies for Postanesthesia Recovery Room, St. Luke's Hospital, Davenport, Iowa

1. 5 wheeled postanesthesia stretchers with 4 inch foam rubber pads, complete with side rails and I.V. standards
2. 1 air conditioning unit
3. 2 oxygen regulators with gauges, humidifier and oxygen tanks
4. 4 portable sphygmomanometers
5. 2 portable suction units
6. Ample storage cabinets and space for storage of drugs, I.V. fluids, and other supplies
7. 1 soiled linen hamper
8. Worktables
9. Wastebaskets
10. Chart desk and chair
11. 5 bedpans, 5 urinals, 5 emesis basins and 5 stainless steel tumblers
12. Blankets, sheets, bath towels, hand towels, patients' gowns, pillow cases
13. Pillows (preferably foam rubber for easy washing—daily)
14. 10 thermometer jars and 5 rectal and 5 oral thermometers
15. 1000 cc. graduate
16. Tongue blades and jar or other container for same
17. Sponge or lifting forceps and jar for sterile forceps
18. Container of sterile cotton balls
19. Small alcohol dispenser and alcohol
20. 5 clip boards for use in charting (Form is put with patient's chart when patient leaves recovery room—clip board makes it easier to chart.)
21. Pen sets and office supplies such as gummed tape, pencils
22. 1 sterile file and 1 dozen 2 cc. syringes. This item is exchanged daily for newly sterilized one from central supply. Assorted needles
23. 2 small sterilizing drums—1 with sterile sponges and 1 with sterile pads
24. 1 each sterile 5, 10 and 20 cc. syringes. Assorted needles, sterile.
25. 3 sterile irrigating sets
26. Sterile continuous and straight drainage sets for G.U. patients
27. An assortment of the usual drugs for care of postsurgical patients and emergency drugs, such as adrenalin, digitalis and narcotics
28. Assortment of intravenous solutions and administration sets

Four-bed ward before conversion into postanesthesia room.

The recovery room currently in use at St. Luke's Hospital.

the individual unit until he has recovered from the anesthetic and is out of danger. Usually, this meant three general duty nurses and two students. This is a prime saving of nurses and we had need for their services elsewhere in our expanded units.

The intangible return on this investment is large. We had the first postanesthesia recovery room in the area. The newspapers gave us a generous amount of space, including a picture, and a reporter did a fine job on the story. The public was much interested. The response to the news story was small compared to the word-of-mouth advertising the recovery room received. Members of patients' families were warm in their praise of the service to the patient following surgery and the close observation their loved one received and the availability of the equipment for any emergency. Patients told us that they liked the constant individual attention and care given them in the recovery room. They mentioned how wonderful the nurses were to them and how much attention they received.

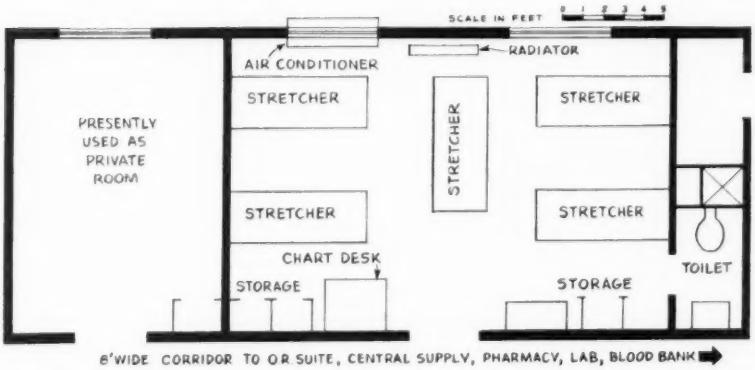
We put the recovery room into operation on June 24, 1953, with four postanesthesia stretchers. We added the fifth in January 1954. From that date to March 1, 1954, 943 patients had been cared for. Owing to shortage of nursing personnel, we operate on a five-day schedule in the operating rooms. January 1954 had 20 regularly scheduled days and 142 patients went to the recovery room. Others had to be sent back to the floor for care as the recovery room could not handle the full load.

We are faced with a problem: more space for the recovery room. We have had pressure from the surgeons and the anesthesiologists. We can take out a wall on the south side of the present recovery room and increase the capacity from five to nine. This would involve an expenditure of an additional $2200 for equipment, including the four additional stretchers and additional air-conditioning equipment. We feel that the air conditioning is a must, since the patient is brought from air-conditioned operating rooms to the recovery room. The removal of the wall would give us an additional 10 feet by 14 feet 6 inches at a remodeling cost of about $500.

There is no doubt that the change would be a good investment; our problem is to find the funds for this. After all, we have spent $1,700,000 for additions, alterations and equipment in the last three years. We have just completed a remodeling project for a pediatric unit costing in excess of $15,000, most of which was donated to the hospital since the drive for funds to build and equip the new addition.

We think that it will come to pass before the end of the year that our recovery room will be enlarged. It is a most worthy project.

Do you have a recovery room in your hospital? If not, you should start now to consider the need and how you can accomplish it. You will find it a good investment in better patient care—better care for which your patients and their families will praise you and thank you because they will appreciate your interest in their personal welfare.



Plan of the existing recovery room showing the arrangement of stretchers and equipment. At left is the private room which can be converted to increase the capacity of the unit by another badly needed four beds.

Malpractice Insurance—Its Need and Purpose

How malpractice insurance differs from general liability insurance—what it covers—why it is important to hospitals

RICHARD C. SLEEPER, C.P.C.U., and DWIGHT W. SLEEPER
Associate Consultant and Chief Consultant, Respectively
Insurance Buyers' Council, Harwich Port, Mass.

IN THE first article of this series we discussed at some length the liability imposed upon charitable hospitals by the courts and legislatures of some of the states and the immunity granted to such institutions by other states. In this article we shall assume that our readers admit the need for insurance covering their liability for bodily injury to persons, whether patients, visitors, or strangers to the hospital, and shall attempt to distinguish between so-called general liability insurance and the need for and purpose of malpractice liability insurance, or hospital professional liability insurance, as it is called in the insurance business.

The confusion which seems to exist about the dividing line between these two types of insurance is illustrated by a misunderstanding on the part of an able hospital administrator with whom we discussed the question recently. This hospital administrator purchases a comprehensive general liability policy but does not buy professional liability insurance. In discussing the reasons for this with this executive, it was brought out that no claims for injury to patients were ever submitted to the insurance company, but only those claims made by visitors or other nonpatients injured on or about its premises, because the administrator understood that any injury of patients caused by negligence or omissions of any kind would be considered as malpractice, and so outside of the scope of the insurance policy. That is an erroneous conception, and the limitations and extent of each type of coverage need to be clearly understood.

GENERAL LIABILITY INSURANCE

General liability insurance covers the cost of investigating, defending, and paying damages arising out of *accidents* for which the assured may be legally liable, because of (1) its ownership, occupancy, maintenance and management of the premises and elevators; (2) the acts of its employes wherever they cause accidents; (3) contingent liability for accidents caused by the negligence of independent contractors, and (4) liability of others assumed under leases or other contracts. The causes of accidents which come within the scope of this type of insurance are common to all business activities. While each of these sections of liability coverage can be insured under individual policies, or some sections and not others can be insured under a schedule liability policy, the more modern type of contract, known as a comprehensive general liability policy, will automatically cover all exposures to claims for damages arising out of *accidents* for which the insured may be legally liable for any cause except those specifically excluded by the policy.

While the comprehensive general liability policy with its companion, comprehensive automobile liability policy, will normally provide adequate liability insurance protection for most types of business activities, this is not true with respect to hospital activities. The reason for this lies in the definition of the phrase "caused by accident" as used in the policy, and the exclusions which will always be used in a policy insuring a hospital.

An accident is defined as "a sudden and unforeseeable event." Injury to persons within a hospital may result from many causes which do not fall within this definition. In order to be accidental, the injury must have occurred at a definite time. Continued or repeated exposure to some condition such as the leakage of x-rays, or exposure to contagious diseases, will surely not be considered as accidents. If the result of an event is foreseeable, injury so caused would not be accidental. If an unenclosed motor is used in the vicinity of explosive anesthetic gases and an explosion occurs injuring a patient, the insurance company would seem to be on sound ground in denying liability because the consequences of this event should have been foreseen. If the admittance office of the hospital is warned that an entering patient needs prompt medical care and delays the admittance of the patient so long that the patient suffers injury, and sues the hospital as a result of this, it is doubtful that it will be considered that this injury was accidental. Many more examples could be given, but they would only serve further to illustrate that a liability policy limited to cover on an "accident" basis does not provide complete protection for the hospital.

The usual comprehensive general liability policy excludes bodily injury arising out of:

1. Malpractice, error, negligence or mistake in rendering of medical, surgical, nursing or hospital services.
2. Rendering of any professional

This is the second in a series of three articles covering hospital liability insurance. The first article appeared in the August issue of The MODERN HOSPITAL. In the next and final article of this series, which will appear next month, the authors will discuss the objections of most insurance companies to insuring hospital liability risks and show how these objections may be overcome, and will include information about how the premiums are calculated and how such costs can be reduced.

services or treatment or omission thereof by any doctor, dentist, nurse, chiropractor or other person.

3. Rendering of any occupational service or the omission thereof by any masseur, chiropodist, barber, hairdresser, manicurist or beauty parlor operator or assistant.

4. Preparing, compounding, filling any prescription, dispensing, sale or misdelivery of any drugs, medicines or optical appliances.

Also, inasmuch as the comprehensive general liability policy is insuring only against claims for bodily injury (and property damage, if desired), the policy would not insure against claims for mental anguish or other personal injuries which may arise.

MALPRACTICE LIABILITY INSURANCE

Until June 1952, there was little uniformity in the insurance coverage which was provided by the various insurance companies to close the gaps in protection left by the general liability policy. Although one or two of the companies did offer a general liability and professional liability policy for hospitals, many hospitals found it necessary, for varying reasons, to purchase their general liability policy from one company and their professional liability policy from another. This situation was undesirable, inasmuch as there was the possibility of exclusions in one policy which were not covered by the other, and the further possibility that in the event of injury to some person, the companies would find it difficult to come to agreement as to whether the injury resulted from an accident or some cause covered by the malpractice policy.

After a long period of discussion among the insurance companies, the American Hospital Association, and other interested parties, the rules and rates pertaining to hospital professional liability insurance were brought under the control of one national rating organization and a standard form and schedule of rates was adopted. Most of the insurance companies have accepted these rules and coverage, although a few of the independent companies may deviate from these.

Hospital professional liability insurance may now be written as an endorsement to the comprehensive general liability policy. Although the companies sell the new combined coverage to insure all of the exposures of the hospital to claims for bodily injury or personal injury, there is some doubt that this is so. While the coverage now provided is broad, we fear that when the wording of the present form is interpreted by the courts, some gaps may still be found to exist.

The new hospital professional liability endorsement, in addition to covering the usual cost of investigation and defense, provides for the payment on behalf of the assured of all sums which the assured shall become legally obligated to pay as damages because of *injury*, including death, sustained by any persons arising out of malpractice, error or mistakes: (a) in rendering or failing to render to such persons, or to the persons inflicting the injury, medical, surgical, dental or nursing treatment, including the furnishing of food or beverages in connection therewith, or (b) in furnishing or dispensing drugs or medical, dental or surgical supplies or appliances if the injury occurs after the insured has relinquished possession thereof to others, or (c) in handling or performing autopsies on diseased human bodies.

A comparison of this wording with the exclusions previously cited will show that there is some possibility that more is excluded than is later included by the malpractice endorsement. The policy first excludes malpractice, error, negligence or mistake in rendering of medical, surgical, nursing or hospital services, or the rendering of any *professional services* or treatment or omission thereof by any doctor, dentist, nurse, chiropractor or other person, while the malpractice endorsement is worded to include only malpractice, error or mistake in rendering or failing to render to such person or to the person inflicting the injury, medical, surgical, dental or nursing treatment, including the furnishing of food or beverages in connection therewith. Has the policy excluded any hospital services or professional services which are not covered by the malpractice endorsement? This is a legal question which we will not attempt to answer, but until the insurance companies adopt a change in wording we fear it is a question that some day will have to be interpreted by the courts.

The comprehensive general liability policy excludes any injury resulting from the preparation, compounding or filling of any prescriptions, or the dispensing, sales or misdelivery of any drugs, medicines or optical appliances. The malpractice endorsement, on the other hand, picks up only injuries arising out of malpractice, error or mistakes in furnishing or dispensing of drugs, or medical, surgical or dental supplies or appliances *if the injury occurs after the insured has relinquished possession thereof to others*. This leaves a serious gap in coverage which we cannot believe is intended by the insurance companies. It is probable that the insurance companies intend that injury caused by malpractice, error or mistake in the furnishing or dispensing of drugs *in* the hospital by hospital employes will be covered by the first section of the endorsement referring to the rendering or failing to render medical, surgical, dental or nursing treatment. Whether or not this intention will stand the test of claims will have to be seen.

The foregoing remarks will not apply equally to all policies, for the wording of the exclusions in the general liability policy differs among the various insurance companies. The wording of the new professional liability form is followed by almost all companies, but each seems to use its own judgment about the wording of its exclusions, and this is probably the biggest cause of the gaps in coverage which have been found to exist.

It is only fair to state that the national rating organization realizes this problem, and a top level committee has been formed to study the problem and to recommend a standard set of exclusions which will plainly state the

Hospital professional liability insurance is necessary fully to protect the hospital against liability for injury to patients from causes which are excluded from the comprehensive general liability policy.

companies' intentions and dovetail with the coverage provided by the malpractice endorsement. Until this work is completed, however, each hospital will have to examine its own contracts carefully to find the gaps and insist on whatever changes are necessary to clarify the coverage.

The policy excludes any error or mistakes on the part of any masseur, chiropodist, barber, hairdresser, manicurist, or beauty operator or assistant, and it is certainly not the intention of the hospital professional liability endorsement to cover this. If any hospital has such persons in its employ, or if such services are provided or arranged for by the hospital, separate insurance must be provided covering the activities of these persons, with the policy extended to insure the hospital also.

The new hospital professional liability endorsement is broader than the basic liability policy in that it covers all injury to persons and not just bodily injury. Thus, it will include mental anguish or any other type of personal injury suffered by persons arising out of events for which the hospital may be legally liable within the scope of the endorsement.

The hospital professional liability endorsement not only covers the hospital's legal liability for injury to patients but also extends to cover its liability for injuries to third parties arising out of the actions of the patients. For example, a claim of this kind could arise if a patient is prematurely discharged and as a result he loses control of an automobile and injures some other person, or if through failure to maintain proper security precautions a deranged person escapes and inflicts injuries on others.

MARGINAL CASES

This article was begun with an example of a hospital administrator who was under the impression that a comprehensive general liability policy did not cover the hospital's liability for bodily injury to patients. This is incorrect, although there may be often a fine line dividing injuries to patients which will be accepted as covered and those which will be denied by the insurance company. Generally speaking, any accidental injury to a patient which is caused by a failure safely to maintain the premises, including elevators and nonprofessional equipment, will be covered by a general liability policy. Injury to patients resulting from the failure to provide or safely to maintain professional equipment or which results from a failure to provide proper professional services will not be covered unless the professional liability endorsement is attached to the policy.

A few examples may be of help in illustrating this distinction. We believe that bodily injury resulting from the following causes will definitely be covered by the general liability policy:

1. A patient who is injured in a falling elevator.

2. Patients who are injured as a result of an explosion of a boiler in the hospital resulting from faulty maintenance of this boiler.

3. The collapse of a chair in the admittance office of the hospital.

Accidents of the following kind which do not arise directly from a lack of supervision or from error or mistake or negligence in rendering professional services would probably not be covered under the general liability policy, although some companies may interpret their coverage more liberally than others:

1. Injury caused by the collapse of an operating table, wheel stretcher, or other professional equipment.

2. Injury caused by the escape of anesthetic gases caused by a fall of the container owing to a failure to secure the container in its storage location.

3. Explosion in an operating room owing to a failure to take recommended precautions against explosion.

There are many types of accidents which will be borderline cases that will depend on the interpretation of the insurance companies or of the courts, if the cases go into litigation. They include such accidents as the following:

1. In a recent accident, a patient being returned to his room from surgery was being wheeled into an elevator, when a wheel of the stretcher turned sideways and dropped into a space between the corridor floor and the elevator platform, throwing the patient to the side with the result that his arm was caught between the elevator and shaftway doors, causing a dislocation of his shoulder. Was this accident a failure properly to maintain the premises and elevator, or a lack of supervision by the attendant?

2. If a hospital burns from a cause not due to the negligence of the hospital, and patients are trapped in the building because of *insufficient exits*, would this be covered by the general liability policy without a hospital professional liability endorsement, or not? If the same situation occurred in a department store, the insurance company would defend the claim and pay any sums that the insured became obligated to pay because of its legal liability, and yet it has been argued that the same failure in a hospital would be one of negligence in providing proper professional services.

3. In a recent case, a patient was injured when a light over an operating table pulled loose from the ceiling and dropped on the patient, severely injuring him. Is the failure properly to install this light an act of professional malpractice on the grounds that it is a piece of professional equipment, or simply a failure to maintain the premises?

FALLS ARE MAJOR PROBLEM

4. It is said that the commonest form of hospital accident is the fall of a patient from a bed. Such falls are a constant source of concern to the hospitals, although fortunately in only a relatively few cases do the patients allege negligence on the part of hospital employes and enter claims for damages. When such a claim is made, however, the specific circumstances attending the accident must be investigated to determine if it came within the scope of a general liability or hospital professional liability insurance. Where the fall is occasioned by defective equipment, a general liability insurance carrier may be willing to investigate, defend and pay the claim if necessary; but if the fall is alleged to be due to negligence in providing proper protective rails on the bed, or to a lack of proper supervision, the insurance companies will probably hold that it is a case of hospital malpractice.

Not only was our hospital friend in error in his assumption that the general liability policy does not cover accidents to patients, but his misunderstanding exposed the hospital to a hazard which he had not intended. He stated that, although he did report accidents to nonpatients to the insurance company for investigation and settlement, he never reported accidents of any kind suffered by patients. Let us see what could be the consequences of this procedure. His hospital happens to be located in the state of Maryland, where a statute provides that

(*Continued on Page* 154)

The True Function of the Nurse

Holding the line against the tendency toward inhumanity, the nurse does her professional duty, but she humanizes it

ROBERT REDFIELD
Professor of Anthropology, University of Chicago

ALBERT SCHWEITZER tells us that he decided to become a medical doctor in Equatorial Africa so that he might work without having to talk. He felt that he had talked enough as a theological teacher and preacher and he wanted to put his religion of love into practice. Apparently he is today content at his jungle station in Lambaréné, and I do not suppose he misses the audiences to which he used to preach. The organ is there on which he may express himself, and the rest is serving by doing.

Every profession offers the satisfaction of direct action. Each tells us that while talk is good, action is better. A profession is a permanent assignment to some sector of human need. To enter one of them is to commit yourself to a responsible position in some long series of troubles and crises. When the cry goes up, you will be there.

ACTS THROUGH LEARNING

In the case of the learned professions, the satisfactions of action are gained without loss of the intellectual interests. The law, the ministry, the various medical and healing professions brace and delight the mind with complex and specialized knowledge. The professional person acts through learning that the layman does not have. To act well he must understand why he acts, and the acquisition and development of this understanding is a good in itself. It is a good closely bound with the satisfactions of action. The mind and the hand join in a common discipline.

Furthermore, in the true professions, these satisfactions at once of the mind and of the hand are realized only in the course of a certain kind of personal relationship peculiarly compounded. This is the relation between the professional and the man or woman whom he helps. It is a relationship mixed of helper and helpless, knower and ignorant, trusted and trusting. The special knowledge could be terribly abused; therefore it must never be; and every true profession expresses and enforces in code of ethics or Hippocratic oath the important and exacting obligations of responsibility to client or patient. There are holders of special knowledge —those who know how to repair our television sets, for instance—whose relationship to those they help is unprofessionalized. The special knowledge is there, and the dependence is there, but not the same basis for trust that the knowledge will be used altruistically. A true professional is a trustee for some part of the accumulations of science and learning. He acts always in a fiduciary relationship to the ultimate beneficiary.

What I have just said about the professions is familiar enough. Perhaps I say something less familiar when I now assert that some professions are more humane than others. In the sense in which I use the word "humane," the ministry is a humane profession; indeed, it is a profession dependent on its own humanity as much as on its theology. But electrical engineering is not humane at all. We might begin to wonder if medicine is a humane profession.

It will be at once understood that I do not use the word "humane" in a sense as restricted as its use in the title of the "humane society": as referring to one exhibiting compassion toward children and animals. I mean here by "humane" to refer to all the feelings and inclinations proper to man. A humane relationship, in this sense, is a relationship between two people each of whom accords to the other all the feelings and inclinations proper to man. An inhumane relationship is one between a man and a thing, or of course also that between a thing and a thing. If a man treats another man only in part as a human being, and in some part as a thing, the relationship is in that latter part inhumane. Insofar as the attention of the professional is upon a thing, or upon some fragment of the whole human being separated from the rest and so become a thing, the professional is not humane. Insofar as the object on which the professional centrally acts is the human being, as a whole, the profession is humane. These professionals are so situated that they apply their special knowledge to man or woman while taking account of the feelings and inclinations proper to man or woman.

WHAT MAKES HUMANENESS

The circumstances that make for more or less humaneness in the professions lie partly in the knowledge and practice of the profession and partly in the social and personal conditions of professional work. A bridge-building engineer knows people have to ride over his bridge, but his mind is mostly on the bridge, not on the people. The beauty of his bridge comes out of his mechanical problem and his materials and he may achieve a successful bridge without thinking much about the whole nature of man. Architects I know differ greatly among themselves as to their humaneness. Some build houses as if to compel people to adjust to "machines for living." Others create houses so beautiful and so unlivable that it is as if they believed that people went through life solely in a condition of esthetic contemplation. And still others design their houses with atten-

tion to the whole man: a being who wants not only beauty but closet space, furniture that children can climb over, and an opportunity to be pretty messy once in a while.

If every architect lived in a neighborhood composed of families living in the houses he had designed, architecture would be a more humane profession than it is. The general practitioner of the law or of medicine in a small community has to assume responsibility for so many kinds of human interests and difficulties that he is necessarily a humane man. It is bigness, remoteness and specialization that dehumanize. The professional who gets only tax cases or thyroid glands has some difficulty in attending to all the feelings and inclinations proper to a human being. I worked once for a law firm which specialized in legal validation of special assessment proceedings. A special assessment is a kind of tax laid on the property adjoining a street to be improved by a paving or a sewer. I came to be something of an expert in the legal description of sewer manhole covers. It was not a humane occupation.

I am taking the liberty of making these remarks to nurses because the impulse to do so is rooted far back in poignant personal experiences in sickbeds and hospitals. There have been times when I have wished that the profession of medicine had given fuller development to its humane nature. Rolling down the hall toward the elevator that leads upward to the flat table and the tanks of ether and oxygen, I have sought in vain for a fully humane understanding of my situation. No one, I have thought, cares about me; they all care about my appendix. No doubt they will do a good job with my appendix; no appendix in the world will be better dealt with; but in the meantime what happens to me? At such moments I have felt myself less than human. I seemed to be only an adjunct to a clinical chart, a reservoir of bioptic samples.

A modern hospital is a wonderful thing, but it takes human beings apart in more than the obvious sense. It dissects the whole man into clinical specializations; it puts an organ in this department and a function in that laboratory. The human being at the center is dissolved, denied, ignored.

But not quite. Human beings have a wonderful toughness, and manage to stay together in difficult circumstances. If the doctor is the right kind of doctor, and the patient does not hesitate to lay claims on the whole interest of his physician, a good deal of humanity can take place between the enameled walls and within the tight, swift schedule of things to be done to things.

One does not, however, see much of doctors in hospitals—patients don't. That marginal being, the intern, is less rare; his face shown around the door on Tuesday may be remembered as almost familiar when seen again on Friday. But the male beings of this odd world around the patient are for the most part functionaries and not persons. They do not light long enough to become persons. And when their interest does appear, it is absorbingly with some special segment of the anatomy that each of us patients carries around with him apparently for the benefit of hospitals.

In this situation contact with the human race is chiefly maintained through that other and far more important person. She is, indeed, a person in a real sense. She looks at us, almost often, as if we had sentiments and inclinations worthy of mankind. With her our humanity is safe. She will listen to the remarks we make to raise our spirits; she may even laugh at our enfeebled witticisms. She will check the spiritual dissection which is the subtler part of the suffering of the sick.

This female person of the hospital stands between my failing humanity and the tendency of the medical profession to become inhumane. Sometimes I have felt that she and I entered into a sort of mute conspiracy to preserve the essential nature of man. If, seizing a moment when the clinical chart has been placed within my range of vision, I read something written there, she is not so shocked at this breach of taboo as she sometimes appears. Her professional learning struggles with her common humanity. I know, when I ask her a question about my condition, that she answers with that cheerful evasiveness which is her instructed duty, but I know that she knows that this is all pretty much humbug. She has not really forgotten that I am an adult and a rational being. She talks this childish nonsense to me because those beings who rule above her have it so. She does her duty in these matters, but she humanizes that duty. And she will find time to talk to me in the language that people talk, not the language of instructed functionaries. Her simple naturalness will do as much for me as scalpel or belladonna. Her words to me will recompose my nature, will make me again a person. I salute her.

VETERANS ADMINISTRATION NURSES GREET FRENCH VISITOR

French Lt. Genevieve de Galard-Terraube received a warm welcome from nurses at the Veterans Administration Research Hospital, Chicago, which she inspected during her trip across country as the guest of the government. During her visit to Chicago, Lt. de Galard visited the V.A., Passavant and Michael Reese hospitals, and was honored by A.H.A. and A.M.A. official at a reception. The trip was sponsored by Rep. Frances P. Bolton.

When Is a Communication Privileged?

A federal court requires a hospital to disclose the names of a doctor's patients to the revenue department

LEE O. GARBER
Associate Professor of Education
University of Pennsylvania, Philadelphia

A HOSPITAL can be compelled to divulge the names of a doctor's patients to federal income tax authorities when officially requested to do so, according to a recent federal court decision.* Such information, it was held, is not confidential nor "privileged" and does not come under the prohibition of a statute forbidding the disclosure, by a physician, of information acquired in the course of his attendance upon a patient in a professional capacity.

In this case, a summons was issued by a commissioner of internal revenue directing a New York hospital to appear before a special agent of the department to give testimony in a tax liability case against a physician. Specifically, the summons required the hospital to produce its records, books and papers and disclose the names of the patients treated by a particular doctor in the hospital for certain years. The administrator of the hospital refused to comply with the summons and permit the examination of the hospital's records. The court issued an order requiring the hospital to comply and the representatives of the hospital and the doctor appeared before the court and expressed uncertainty as to whether voluntary production of the records was in violation of Section 352 of the New York State Civil Practice Act, which prohibited a physician from disclosing information acquired as a result of attending a patient, professionally. They contended that the hospital's records were confidential, but did not, apparently, contend that an examination of the records would necessarily disclose the nature of the patients' illnesses or the treatments administered, although oral arguments were to this effect.

In considering the case, the court looked into the history of the law on this matter and pointed out that a doctor, at common law, could be required to testify relative to confidential information he had received in a professional capacity. To prohibit such disclosures, laws of the type involved, here, had been passed. In commenting on the nature of such statutes, the court said:

"The nature of the privilege has never been extended to prohibit the disclosure of evidence as to facts not acquired in a professional capacity. Incidents and facts which are plain to the observation of anyone are not within the prohibition. . . . Neither are the voluntary acts or disclosures made or done in the presence of a person not a member of the professions named in the statute. . . . The purpose of the statute is to protect the patient in his relationship with the physician and to prevent the disclosing of information which might result in humiliation, embarrassment or disgrace."

Following its consideration of the nature of the statute, the court reviewed similar cases and pointed out that under such laws a physician had been permitted to testify to the effect that a certain patient had been ill and the number of times he had been treated professionally by a particular doctor. Likewise, it pointed out that a hospital had been permitted to give information as to whether a particular patient had been treated by a certain doctor, together with the date of the patient's entry and discharge from the hospital, and ruled that "the patient-physician relationship must be shown before the privilege may be invoked." In considering the case before it, the court said:

"In applying the holdings in the above cases there is certainly no reason for applying the privilege more liberally when the information is so sought from a hospital than when it is sought from the doctor. One of the four essentials for the establishment of the privilege is that the injury resulting from the disclosure must be greater than the benefit disclosure would afford in disposing of litigation correctly. . . . The public has a definite interest in the just enforcement of taxing statutes. It follows that the benefits which may be afforded by the disclosure in determining litigation outweighs any hypothetical injury."

As a result of its reasoning, the court held the information in question here was not privileged and that the hospital must disclose it to the revenue department. It said:

"Inasmuch as there is no positive evidence here that the books and records of the hospital cannot be inspected to obtain the information authorized without the disclosure of information which may properly be termed confidential, the motion will be denied. The hospital, however, is to take all precautions necessary to ensure that the treatment afforded any patient or the diagnosis of his illness shall not be disclosed."

*In re Albert Lindley Lee Memorial Hospital, 115 F. Supp. 643.

About People

Administrators

Lawrence R. Payne, administrator of Medical Center Hospital, Tyler, Tex., and executive director of the East Texas Hospital Foundation, has been


L. R. Payne


G. B. Pearson

appointed administrator of the new Baptist Memorial Hospital, Jacksonville, Fla., which is now under construction. He is succeeded at Medical Center Hospital by **George B. Pearson,** administrator of Highland Sanitarium, Shreveport, La. Mr. Payne, who has been active in the field of hospital administration since 1932, has served as executive director of the East Texas Hospital Foundation since 1951. He is a former president of the Northwest Texas Hospital Association and former secretary of Blue Cross and Blue Shield in Texas. For several years he served as trustee of the American Hospital Association and of the American Protestant Hospital Association and was a member of the house of delegates of the American Hospital Association. Most recently he was treasurer of Blue Cross-Blue Shield in Texas. He is a fellow of the American College of Hospital Administrators. Mr. Pearson, who received his B.S. degree in hospital administration from Northwestern University, will serve only as administrator of the Medical Center Hospital; he will not act as executive director of the foundation. He is a member of the American Hospital Association, the American College of Hospital Administrtaors, and of the Louisiana Hospital Association.

Dr. F. Lloyd Mussells, who has been serving as acting executive director of Philadelphia General Hospital, Philadelphia, has been named permanent executive director succeeding **Dr. August Groeschel,** who resigned last February. Dr. Mussells came to the hospital in February 1953 as medical director; as executive director he is in charge of over-all administration of the Blockley and Northern divisions of the hospital. Dr. Mussells is a graduate of McGill University Medical School and received his M.S. in hospital administration from Columbia University. He is a member of the American Hospital Association and of the American Public Health Association.

John S. Parke, executive vice president of Presbyterian Hospital at the Columbia-Presbyterian Medical Center, New York City, since 1944, died August 13 at the age of 58. Prior to his association with Columbia-Presbyterian, Mr. Parke supervised the construction of the new buildings at the Center and the Mary Harkness Convalescent Home, Port Chester, N.Y., and other institutional buildings in and around New York City, including Memorial Hospital and New York-Cornell Medical Center. Mr. Parke was a trustee of the Blood Transfusion Association, a member of the board of governors of the Greater New York Hospital Association, a member of the American Hospital Association's council on hospital planning and plant operation, and a member of both the American College of Hospital Administrators and the Protestant Hospital Association.


John S. Parke

Dr. Benjamin G. Dinin, medical superintendent of Cumberland Hospital, Brooklyn, N.Y., has been appointed medical superintendent of Metropolitan Hospital, Welfare Island, New York.

John W. Bentz, former administrator of Arkansas City Memorial Hospital, Arkansas City, Kan., has been named administrator of McPherson County Hospital, McPherson, Kan. Mr. Bentz is a member of the American Hospital Association and the Kansas State Hospital Association and is a senior member of the American Association of Hospital Accountants.

William A. Markey, formerly administrative resident at Beth Israel Hospital, Boston, is now assistant director of the outpatient department at Montefiore Hospital, Pittsburgh. Mr. Markey is a graduate of the Yale University course in hospital administration.


W. A. Markey

E. R. Andres, administrator of Grandview Hospital, Edinburg, Tex., since 1952, has become administrator of Kleberg County Hospital, Kingsville, Tex.

Dr. A. L. Swanson, executive director of the Canadian Hospital Association and editor of the *Canadian Hospital,* has become administrator of the new University of Saskatchewan Hospital, Saskatoon, Sask. Dr. Swanson, a graduate of McGill University Medical School, received his M.S. in hospital


Dr. A. L. Swanson


Dr. W. D. Piercey

administration from Northwestern University and is a member of the American Hospital Association and of the American College of Hospital Administrators. **Dr. W. Douglas Piercey,** superintendent of Ottawa Civic Hospital, Ottawa, Ont., since 1942, has been appointed to succeed Dr. Swanson. Dr. Piercey, a graduate in medicine from Dalhousie University, Halifax, N.S., is a past president of the Ontario Hospital Association and for the last three years has been a member of the board of directors of the Canadian Hospital Association.

Dr. A. F. Branton, administrator of Baroness Erlanger Hospital, Chattanooga, Tenn., has resigned. He is succeeded by his first assistant, **Harold Peterson.** Mr. Peterson received his master's degree in hospital adminstration from Northwestern University,

(*Continued on Page* 186)

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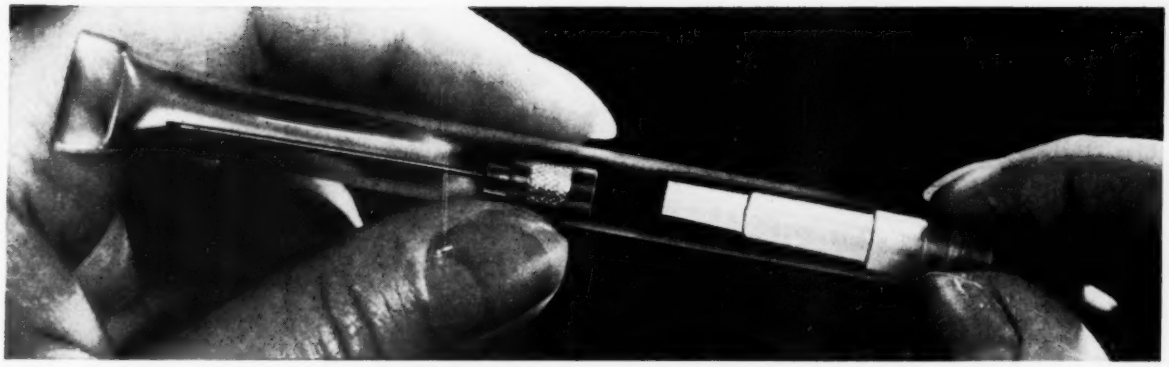

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Volunteer Forum

Conducted by Raymond P. Sloan

An administrator sets forth her ideas on

What Makes a Volunteer Valuable

ABBIE E. DUNKS
Director, Boston Dispensary, Boston

THIS whole hospital world, which has grown so complex in recent years, is a relatively new one and yet in the little more than a century since it has existed its transformation has been astounding. From almshouses for the poverty-stricken and dying, the scene has shifted to one of health centers serving to prevent illness, prolong life and make that longer life worth while. The financial problem has changed too: from philanthropic institutions supported by lords and ladies bountiful, death, taxes and increased costs have forced us to become business organizations depending largely on fees from patients or third parties (meaning insurance companies or public welfare officials). At the same time, miracles in medicine have made us more and more halls of science and, remarkable as that has been in the cure of the physical illness of the patient, it has sometimes brought with it the danger of our losing sight of the human being who is ill, which is equally important to the patient's recovery, and should be of particular concern to women's auxiliaries.

HOSPITALS HAVE LACKED SUPPORT

While industry and medicine have made tremendous strides in recent years because of the large research funds available to them, hospitals have lacked such support. Regional and national hospital associations are now seeking funds and planning programs which will attempt to resolve the acute illnesses of our hospitals at present and provide a sound basis for their future.

In an attempt to cope intelligently with the complexities of hospital organization, graduate courses have been set up to train leaders in the field of administration. We are finding, therefore, in small as well as large hospitals, that instead of a nursing superintendent to handle professional matters and a volunteer treasurer on the board to handle financial affairs, something new has been added: the trained hospital administrator. Nevertheless, in spite of better preparation, he or she is increasingly faced with difficult basic problems: physicians who want more and more facilities but are often reluctant to face the financial facts of life, increasing scarcity of nurses, class distinctions between groups of employes which are difficult to reconcile but necessary to overcome if full teamwork is to be achieved, in fact, all the personnel problems to be encountered in managing a small community. To add to the internal turmoil there is a background of fear of government control of hospitals, a necessity for retaining tactful relationships with both public and private agencies, and, sometimes, board members who may in theory have placed the administrator in charge of the hospital but in practice like to tell him how to do it. Doesn't it sound like a Herculean task?

Is it surprising that when the subject of hospital auxiliaries is mentioned as a new factor the already harassed administrator may groan? Now I know auxiliaries can be valuable. They can help both with the personnel and with the financial responsibilities, *provided* — and it is the hows and ifs I want to discuss.

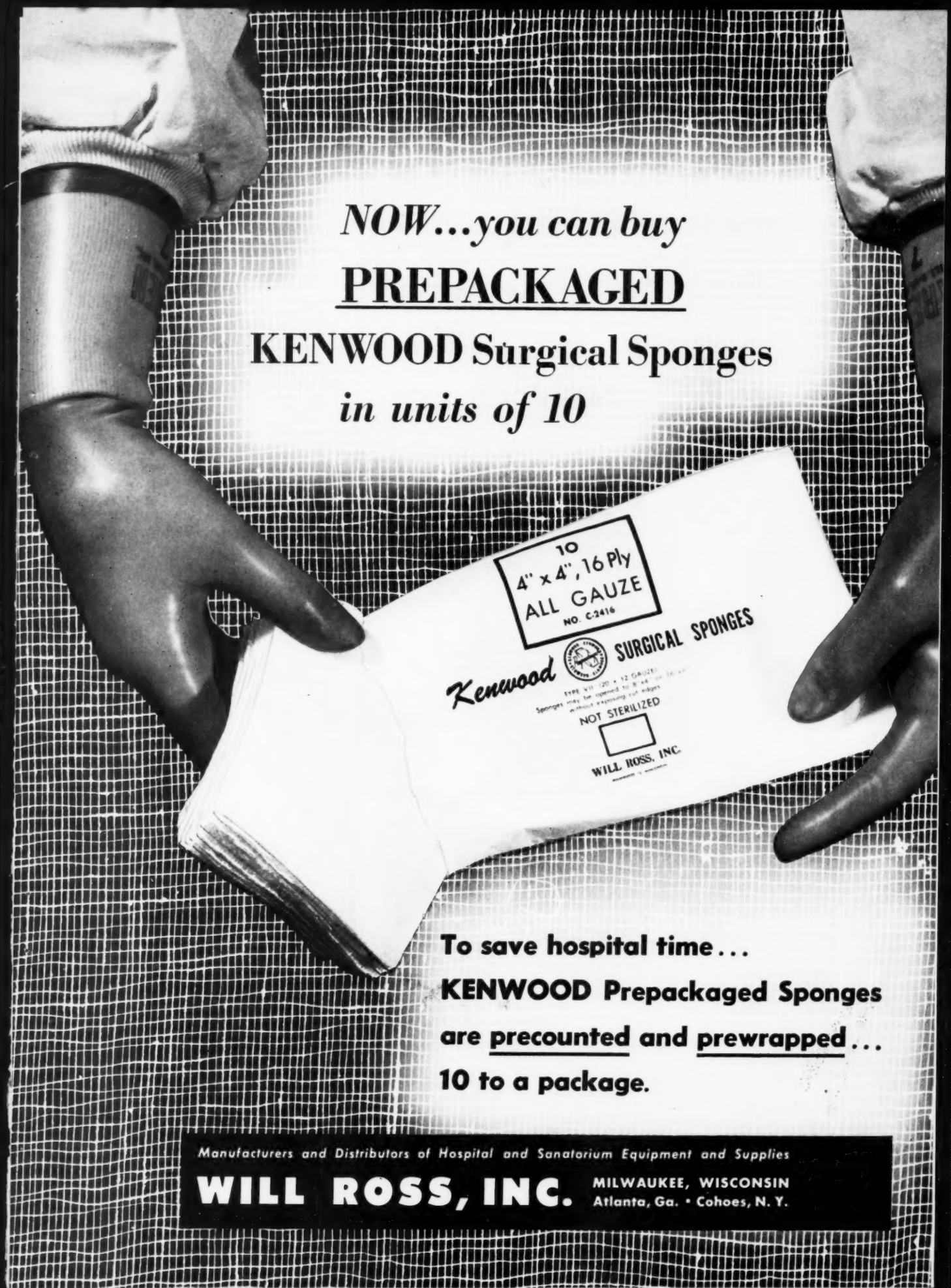
You probably have heard of the man who dropped into a church in a strange community just as the congregation was reciting in unison "we have done those things which we ought not to have done and have left undone those things which we ought to have done." With a sigh of relief he sank into a pew murmuring "My crowd at last." We all belong to that crowd. We have committed sins of omission and commission in our hospital service. Let's try now to get together. The days of well meaning amateurs in women's hospital auxiliaries are numbered. Hospitals in which auxiliaries take part make us increasingly aware of the educational possibilities available through the state and national hospital associations for the rôle that women may play in the hospital of the future. By participation in such meetings one finds that almost no local situation is unique and learns, by sharing with others, how to deal intelligently with it.

THEY SHOULD BE REPRESENTED

Furthermore, if auxiliaries are worthy of acceptance as part of the hospital organization and destined to be its interpreter they should have a representative on the board of trustees of the hospital. Whether she is an an ex officio or voting member is unimportant; she should certainly be present at the deliberations of those responsible for policy-making decisions before she can assume an intelligent rôle in guiding her auxiliary members. The auxiliary must also recognize that the trustees have placed upon the administrator the responsibility for the conduct of the hospital and therefore he should assist with and approve of any changes in auxiliary functions.

Assuming that the first steps of membership in the national hospital associations, membership on the hospital board, and proper integration into the administrative setup of the hospital

Condensed from a paper presented at the annual meeting of the Vermont Hospital Association, October 1952.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have been achieved, how can the administrator look for help from the auxiliary?

Important as money is in the operation of the hospital, I think it is more important that the auxiliaries really know their hospital and know how to tell its story to others before they undertake any money raising project. There are various ways in which that can be accomplished. (1) Have the administrator, and through him key members of the staff, speak briefly at auxiliary meetings. The group will learn of breath-taking developments in modern medicine, and the difficulties in supplying them in today's hospital. (2) Appoint small visiting committees that will periodically tour the hospital with the administrator. They will quickly realize that physical plant and equipment need constant attention. (3) Support legislation which will improve hospital service. In Massachusetts where we are conducting an active campaign in public education and are seeking additional reimbursement from the legislature for the care of welfare patients, I attended a meeting where fully one-third of those present were representatives of women's auxiliaries. I consider that striking evidence of intellectual maturity. (4) Work as a volunteer in the hospital. I should like to talk a little more about the service volunteer in the hospital. Because well meaning women have sometimes caused complications instead of easing the hospital's problems I should like to enumerate a half dozen characteristics which I should like to see in the ideal volunteer.

MUST BE DEPENDABLE

First, she should be dependable. Some of the jobs assigned to volunteers seem relatively unimportant, but they may be far-reaching in their implication. Most of us are not doing extraordinary pieces of work day after day, but to do something ordinary extraordinarily well is vastly more important.

Second, the volunteer must be discreet. This is particularly true in a community where the volunteer may learn intimate and privileged facts about a neighbor. We must guard against gossip in our hospital relations.

Third, the volunteer must be cooperative. One is entitled to feel a little magnanimous about contributing service for which others are being paid, but we must all function as part of the team and not, as Don Marquis says, think we are heroes when we are

only cinders in the eyes of humanity.

Next, we want intelligent volunteers. Somebody has said there are two kinds of people, the different and the indifferent. We want our volunteers to be interested in any job they have to do, and also in the new and challenging developments about them. There is a lot of red tape in hospital work today, some of which, I am sure, is unnecessary. A volunteer who is alert enough to distinguish the unnecessary from the essential and tactful enough to ask questions or make suggestions in an objective way is an asset to the hospital. Elbert Hubbard said that the recipe for perpetual ignorance is to be satisfied with your opinion and content with your knowledge. I hope you have no auxiliary members in that category —those who think they are thinking when they are merely rearranging their prejudices.

Finally, and most important of all, it behooves the volunteer to be kind. We have gone a long way from the cool hand on the fevered brow of fiction in our great modern scientific institutions; sometimes, I think, we have gone too far. There are times when we become brusque and impersonal; there are times when all our accumulated knowledge fails and only an understanding heart can help. The volunteer can take the time to be kind to patients, all of whom are frightened, and many of whom are suffering. No doubt they are difficult and unreasonable at times. There aren't many people who are normal when they are sick; in fact, there aren't many normal people anyway!

I have spent a good deal of time discussing auxiliaries as the human relations and public relations representative of their hospitals. Let us spend a few minutes on ways in which they can use their money, as well as their talents. Where they get the money is not in my department, but I have attended enough auxiliary meetings to know that their ingenuity in money raising is immeasurable, provided they have an objective.

I should like to mention, first, assistance to the administrator in the recruitment and the retention of personnel. If the hospital has a training school the auxiliary can offer a scholarship. It can finance attendance for graduate nurses at postgraduate institutes. It can offer social programs for undergraduates, resident or other personnel; holiday teas for staff, workers and volunteers at which volunteers act as hostesses; periodic service awards for merit or length of employment. Any method which the volunteers, with the administrator's approval, may devise, will be one more incentive to counteract the competition for workers.

Second, they can finance new special services on a large scale such as provision of a formula room, a blood bank, a premature nursery. Or, if some new service is to be added which does not involve as much expenditure for building changes and equipment as those I have mentioned, the auxiliary can undertake to finance the personnel in the new department for a year or more until it has proved its value and can be taken over as part of the regular hospital budget.

Third, there are the smaller items of special equipment or supplies which the administrator would like to provide from time to time to improve the efficiency of service—a high speed sterilizer, a portable x-ray unit, a portable electrocardiograph. The very expensive new drugs needed by patients unable to pay for them are a constant drain on the budget. Every administrator will have additional ideas.

LET ADMINISTRATOR BE GUIDE

Fourth, there are the decorative extras which give a homelike atmosphere to hospital or dormitory: slip covers, colorful prints for the walls, flowers for the lobby, reading lamps. But the volunteers must not let their decorative enthusiasm carry them away. Materials suitable for a home may be most unsatisfactory in an institution. Let the administrator be the guide.

To summarize, auxiliaries should get acquainted with their hospital in order that they may represent it intelligently in the community. Then, they must render financial help: in launching new projects which the developments in the field of medicine or the complexities of hospital organization may make desirable; in providing new equipment that will save hours of labor and even human lives; in helping the administrator to initiate and sustain sound personnel relations.

The auxiliary should be standing by to interpret and to implement the hospital's goal. Most administrators are like the mountaineer who, being offered a banana for the first time, refused because he said that he was not able to satisfy the tastes he already had. We should all be glad to cultivate some new tastes if the volunteers will make it possible.

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[1]Barry, C. N. and Rose, D. K.: Urokon Sodium 70% in Excretory Urography, J. Urol. *69:* 849 (1953).

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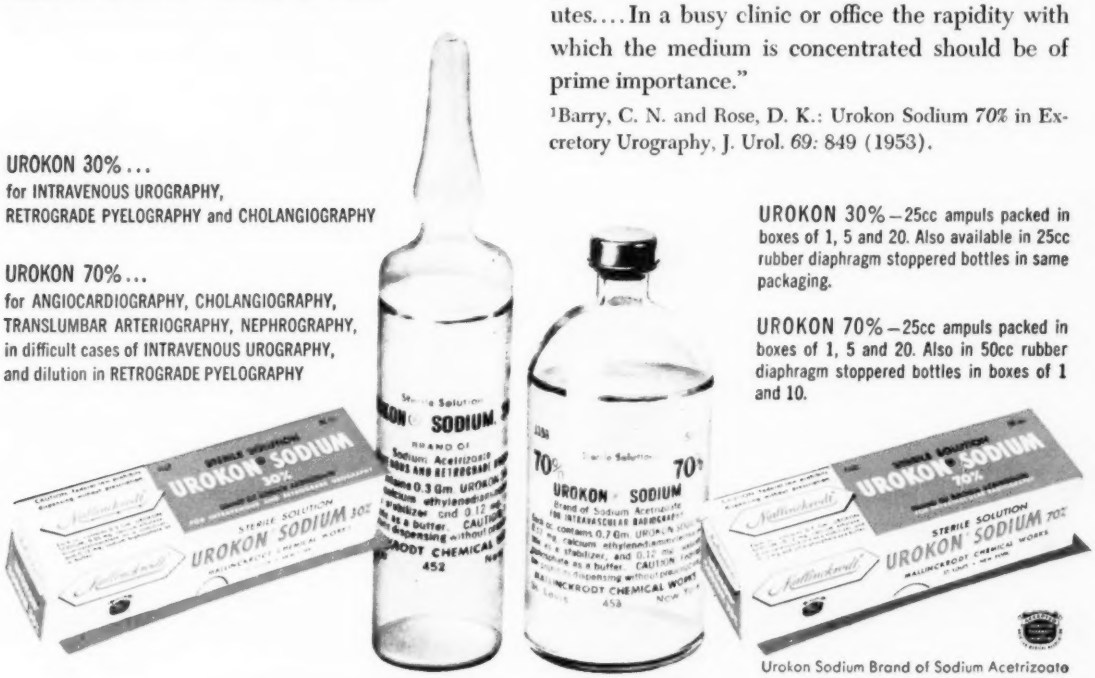

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Conducted by Robert F. Brown, M.D.

There are three obstacles to overcome in

Developing the Medical Audit

PAUL R. HAWLEY, M.D.
Director, American College of Surgeons, Chicago

THERE are three principal obstacles to be overcome in attaining adequate control of the quality of medical care. The first of these is human error. The time may come when medical care can be evaluated with mathematical accuracy, but it is not here yet. Many important elements enter into the equation, not a few of which are intangible. For example, one of the criticisms of the medical practice of today is that the personal relationship between patient and physician has deteriorated with the great scientific advances in the past few decades. It might be difficult to convince a scientist of the importance of this factor in medical care. The reactions in his test tubes, and the growth upon his culture media, are not influenced by any such personal factor. They are influenced only by such measurable quantities as weight, temperature and the pH concentration. As science, more and more, has come into medicine, this concept of impersonality has crept into the application of medical technics.

PERSONAL EQUATION IMPORTANT

But I am not so sure that the importance of the personal equation of the physician can be dismissed so lightly. While one of the most intangible of the intangibles of medical care, the will of the patient to recover is still an important influence in the outcome of an illness. No one practices medicine long without encountering examples of this. I remember several.

One of the most striking of these, in my experience, occurred in the case of a fellow medical officer of the regular army. This officer was due for foreign service; and, as was a requirement, he had to undergo a physical examination before leaving. He considered himself to be in perfect health; but a small hernia was discovered and he was ordered to have it repaired.

The operation was completely uneventful. No difficulty was encountered in reducing the tiny hernia, and the repair was made quickly and without any trauma to the contents of the peritoneal cavity. Immediately following the operation he developed paralytic ileus. All efforts to relieve this complication were unsuccessful, and he died within 72 hours.

After his death, his widow began to collect the items of his full-dress uniform in which he was to be buried. She discovered that, before entering the hospital, he had carefully laid these out, together with written instructions for the details of his funeral.

It is conceivable that a lay person might be badly frightened at the prospect of a simple herniorrhaphy; but here was an experienced physician who knew the small risk involved, and who must have known as soon as he regained consciousness that even the small risk was almost entirely over. Yet this man had entered the hospital with the firm expectation, if not the firm intention, of dying; and die he did for no reason which could be clearly explained.

On the other hand, we see patients recover from disease or accident, who, measured by scientific yardsticks, cannot possibly recover. So, the will of the patient to recover, while it cannot be measured in units of force, is a very real factor; and this will is influenced, consciously or subconsciously, by his confidence in his physician, his nurse, and his hospital.

THE SECOND OBSTACLE

The second obstacle to accurate measurement of the quality of medical care is the great gaps in our knowledge of both the human body and the afflictions to which it is subject. Notwithstanding the many facts which have been established in recent years, there remain many conflicting theories and honest differences of opinion. Furthermore, so much that we *knew* yesterday is *not* true today. Who can say what is right and what is wrong in these areas of obscure vision?

We must remember the history of therapeutics. The physician who failed to let blood in a fever a century or so ago would have fared badly in a medical audit of his day. Still more recently, the ovaries removed by Lawson Tait would have shocked a conscientious tissue committee of 1954. Much that was accepted as standard practice only a lifetime ago would be regarded as malpractice today. So, in developing a pattern for evaluation of the quality of medical care, we must assure sufficient flexibility to adjust to variations in contemporary thought.

The third, and perhaps the greatest, obstacle to the establishment of ade-

Condensed from a paper presented at the annual meeting of the Southwestern Michigan Hospital Council, June 1954.

when resistance to other antibiotics develops...

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(1) Kirby, W. M. M.; Waddington, W. S., & Doornink, G. M.: Antibiotics Annual, 1953-1954, New York, Medical Encyclopedia, Inc., 1953, p. 285. (2) Finland, M., & Haight, T. H.: *Arch. Int. Med.* **91**: 143, 1953.

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quate control of the quality of medical care is the resistance of the medical profession to interference with the individual practitioner of medicine. This traditional attitude of doctors cannot be understood unless we are familiar with the history of medical practice.

While there were physicians before the time of Christ, and some teachers of medicine, perhaps the first standardization and formalization of medical theory was done by Galen, in the Second Century, A.D. You will note that I used the term "medical theory" rather than "medical knowledge." I did this advisedly, because medical knowledge was extremely scant in Galen's time. This paucity of fact did not deter Galen, however; and he erected, from some acquaintance with gross anatomy and the remainder by pure speculation, a comprehensive system of diagnosis and treatment of human ailments. As one illustration that his poverty of fact was no deterrent to the exercise of his imagination, he evolved the hypothesis that there was no circulation of the blood, but that the blood ebbed and flowed with each beat of the heart. He taught also that the arterial blood carries vital spirits from the heart, and that the venous blood carries natural spirits from the liver. There were other phenomena which could not be explained without the existence of some communication between arterial and venous blood. Since Galen knew nothing of microscopic anatomy, and hence was ignorant of the existence of capillaries, he invented invisible pores through the septum separating the ventricles of the heart — pores which, of course, he could not see, nor could he have found them even with a microscope.

DOGMA REMAINED UNQUESTIONED

One might expect that, as bits were added from time to time to the knowledge of anatomy, Galen's fantasies would have been dispelled, one by one. Such, however, was not the temper of the times. These were the days when learning was imparted with the force of authority. Whatever had been decided by responsible authority, whether in the church or in the sciences, was law; and any questioning of established dogma was branded as heresy, and dealt with accordingly.

So, Galen's system of medical teaching was regarded as gospel for 14 centuries. Obviously, there was little medical investigation during this period; and such as was done rarely saw the light because of the persecution of heretics. Even when William Harvey, in 1628, proved the circulation of the blood, he was denounced throughout Europe as an anti-Christ. Thus, perhaps, did the doctrine of infallibility of the physician originate.

While Harvey broke the bonds which had fettered medical research for 1400 years, and while knowledge of anatomy — gross and microscopic, including pathologic anatomy — was greatly expanded in the next 250 years, actually there was little known about the cause, prevention and cure of disease until Pasteur inaugurated the modern era of diagnosis and treat ment, and this has taken some 75 years to develop to our present standards, which are yet far from perfect.

So, until quite recently, the practitioner of medicine had the choice only between confession of the great gaps in his medical knowledge and the adoption of a protective armor of infallibility. For reasons other than of his own making, he chose the latter alternative. The public, when faced with death, was entirely unable to rationalize admissions of ignorance by its one source of hope. It is the unknown which forces mankind to invent sources of support, and people are sustained by faith in these creations. As the limits of the unknown are pushed back by the expansion of knowledge, more and more terrifying phenomena are explained, and man relies less and less upon faith. There are many examples of this. No longer are we terrified by the total eclipse of the sun, and, therefore, we no longer pray to a Supreme Being to protect us from it.

So, the armor of omniscience became the protection of the medical profession against loss of faith by the suffering public. It was *lèse majesté* to question the opinion of the doctor. There was an old, old story in my boyhood, which I am sure you have all heard, which illustrates the thought of the day. Patrick Murphy was ill, and the family doctor was in attendance. Patrick's condition grew progressively worse, and one morning the doctor turned from his examination of Patrick and said to Mrs. Murphy: "I am sorry to tell you, Mrs. Murphy, that Patrick has just died"; whereupon Patrick opened his eyes, sat up in bed and declared indignantly: "I am *not* dead!" Mrs. Murphy gently pushed Patrick down in bed, and said: "Lie down Patrick; the doctor knows best."

Once having adopted the attitude of infallibility, it has been difficult for the medical profession to abandon it. I am not being critical of the profession in saying this. How can we be sure that the public is ready to accept such a change? When his health is excellent and he senses no danger to it, John Doe may accept the limitations of medical knowledge as a natural and reasonable situation. But let John Doe become ill; let him be confronted with the fear of impending death, and John Doe, despite his intelligence and his education, grasps at the straw of faith in his doctor. He *wants* to believe in the infallibility of his doctor and this is no time to offer him equivocal opinions. There comes a time, when faced with great danger with which we cannot cope alone, in which the most civilized of us throw reason away and grasp at faith—just as did our savage ancestors a million years ago. The only difference is that our breaking point is higher.

NOT INSUPERABLE OBSTACLE

I have spent some time upon this characteristic of doctors as an obstacle to the control of the quality of medical care. I do not mean to imply that this is an insuperable obstacle. All I want to do is to suggest that this characteristic be considered in the development of a pattern for a medical audit. I think you will agree with me that the cooperation of the medical staffs in those hospitals in which the pattern of a medical audit is being developed is evidence of the unselfishness of those doctors, and of their devotion to the high principles of their profession. The fact is that the medical audit is an advantage to an able and conscientious doctor; and those who oppose it are open to the suspicion of having defects to conceal.

However, even if these obstacles were much more formidable than they actually are, we must not be deterred in our determination to establish control of the quality of medical care. It is a duty we owe the public. It is also a duty we owe the majority of the medical profession, who practice ably and honestly. I wonder whether you realize that medical care is the only influence upon the well-being of our citizens which is not directly controlled by government. Those factors which influence liberty are controlled

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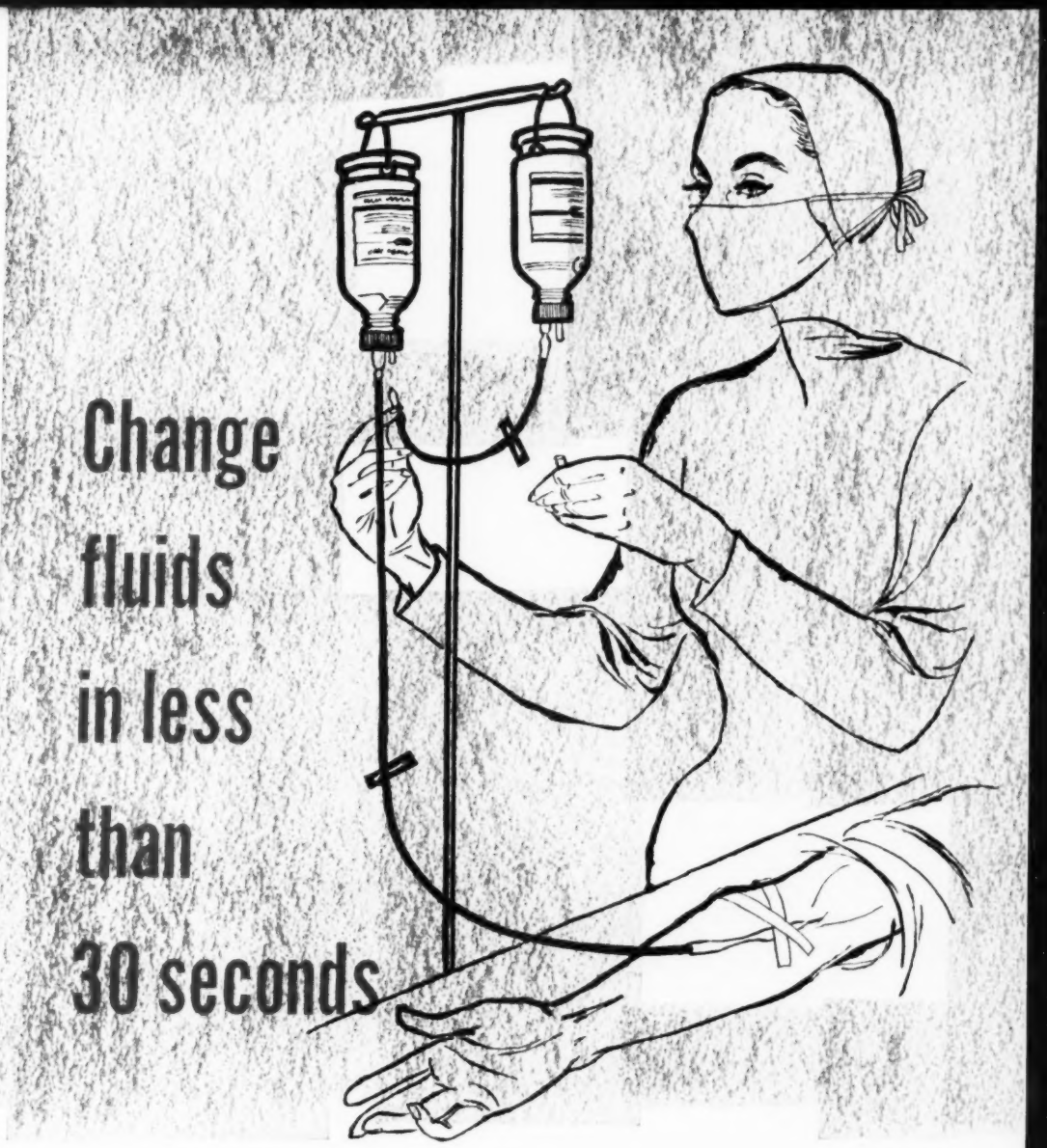

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by the courts. Security in old age has been provided by government—whether or not it is adequate. Medical care alone has escaped government control; and, if we want to keep it that way, *we* must provide the checks and balances. If we do not, you may be sure that, sooner or later, the government will.

I sometimes think it is unfair to place upon hospitals the task of driving evils from medical practice. The profession itself should do this. There is no need to comment upon the success which the profession has had. So, this task has fallen upon hospitals by default. Rather than its being an unpleasant burden upon them, it offers the opportunity to make a great contribution to the public welfare, and I hope hospitals will make the most of it.

On second thought, it occurs to me that a part of this responsibility is rightfully the hospitals' and that they cannot escape it by waiting for others to do their share. More and more the public is choosing its medical care through the selection of hospitals as well as the selection of doctors. If a patient chooses your hospital as the place for his care, the responsibility is yours for the quality you offer him.

This is particularly true of the service cases, and the emergency cases, which are brought to your hospital by chance or because it is most convenient. Such patients rarely have the free choice of doctors. The staff members on service are assigned to them. In such cases, administrators and trustees bear a very heavy responsibility: that the medical care is of a quality which would be satisfactory to them, if they were the patients. I hope that all hospital trustees will remember this one fact: They are the top management of a plant in which both good and evil can be done to their fellow-citizens. Whether good or evil is done depends almost entirely upon them.

While trustees are not expected to be the personal judges of the quality of care given in their plants, they are expected to employ all proper means to measure this quality of care. If they tolerate a quality of care which they would not be perfectly willing to accept for themselves and their families, they are as guilty as those giving bad care. Trustees can have first-class medical care in their hospitals and in their communities. All they have to do is to insist upon it.

A Pyrogen Is a Dangerous Weapon

An expert discusses the source of this "parenteral enemy" and how to eliminate it

RICHARD E. BURGESS
Glendale, Calif.

WHAT is a pyrogen? Let's start off by describing some of the effects on a patient when pyrogen is injected intravenously. Later on we will go into the properties of pyrogen itself.

The first noticeable effect within an hour or so after injection of pyrogen is a shaking chill and sudden fever—109° F. has been recorded. The patient's blood pressure rises, he has rapid breathing, nausea, vomiting, oliguria, and apprehension as of impending death. He further has vasoconstriction, decreased cardiac output, slowed circulation time, depressed gastric motility and depressed gastric secretion, and shock. Meanwhile there has been developing a leucopenia—the white cell count may drop as low as 75 per cent below normal values. The secondary effects which come on after two or three hours represent complete reversals of some of the previous effects. The fever subsides, blood pressure drops below normal, there is vasodilation, increased cardiac output, accelerated circulation time and leucocytosis—the white cell count may rise to 100 per cent above normal.

Reactions due to pyrogen, like diptheria and smallpox, are rare in most hospitals today. The general availability of biologically tested, intravenous solutions and expendable administration sets has removed a large burden from the hospital staff. Because of this, hospital personnel may have forgotten what "pyrogens" are. There is often only a casual acquaintance with facts which a few short years ago were absolutely essential for a successful parenteral therapy program.

Why, then, are we concerned about pyrogen? The answer is that when pyrogen reactions *do* occur the effect is like a well placed hand grenade. Serious disruption of normal activities occurs. Confusion and perplexity are rampant. Suspicion is directed everywhere and, temporarily, faith in commonplace procedures is gone.

Because knowledge of pyrogen can prevent this disruption, it is the purpose of this paper to review certain facts about pyrogen and point out areas which remain a constant threat to the unwary.

THE PYROGEN IS ELUSIVE

Pyrogen has been called Parenteral Enemy No. 1. We know many facts about him. We know his favorite hiding places—unclean, ineffective stills; water exposed to room air; carelessly prepared solutions; inner surfaces and hidden areas of needles, syringes and other equipment. We know his best friends—bacteria, clots and debris remaining in unclean though autoclaved accessories. We have learned his weaknesses—removal by proper cleaning and rinsing methods. We have seen his strength—not destroyed by ordinary autoclaving. He is an elusive enemy. He can pass through most bacterial filters and sustain himself under many adverse conditions.

How many pharmacists have seen a pyrogenic reaction, or know of one recently? For the benefit of the innocent, the following experience of a medium sized hospital a little over a year ago is typical and shows what can still happen if a few fundamentals are ignored:

Over a period of 10 days, five patients had serious reactions during or following surgery. The reactions were a sudden fever within one to two hours after starting an intravenous drip. Fevers went as high as 106° F. or 107° F. with violent, bed-shaking chills. In some cases nausea, sudden fall in blood pressure to undetectable values, renal shutdown, and shock required emergency supportive therapy. Fevers gradually subsided and for 11 days all was quiet. Then suddenly there were two more reactions and the entire surgical unit was shut down. The staff was completely mystified and started a systematic investigation.

Careful bacteriological search showed drugs, solutions, administration equipment and patients' blood to be sterile. However, pyrogen assays in rabbits showed quite a different picture. Nonpyrogenic saline solution passed through hospital needles or syringes and injected into rabbits caused prompt increase in the rabbits' body temperature. Where did the pyrogen come from? Analysis of cleaning operations uncovered the source of the trouble. Ordinary distilled drinking water in five-gallon bottles was used for the final rinse for syringes and needles. This water was strongly pyrogenic

Presented before the pharmacists' section, Association of Western Hospitals annual convention, April 26, 1954.

when tested in rabbits. Inadequate use of an effective detergent was also a contributing cause. Order was at once restored by simple changes of cleaning methods and the use of known nonpyrogenic final rinse water until an adequate still could be installed. Most important, the people doing the cleaning were shown the reasons for the various logical steps and were given an understanding of the lurking danger in the cleaning room.

Another recent example occurred in a smaller hospital. During nearly every blood transfusion, the recipients experienced the frightening effects of a pyrogen reaction. Again, inadequate understanding and poor performance of cleaning operations were the cause. Investigation showed that needles used for venipuncture contained small amounts of residual blood even after cleaning. This blood provided a fertile medium for the growth of pyrogenic bacteria while the needles were waiting to be sterilized. The bacteria were subsequently killed by autoclaving but their toxic products remained in the sterile but insufficiently cleaned needles. The person doing the cleaning didn't know about pyrogens or how they are formed.

Pyrogenic reactions in another hospital were traced to the trapping effect of a loop of rubber tubing on the delivery line from an otherwise adequate water still. This loop trapped water and provided ideal conditions for formation of pyrogenic materials since it never drained completely. There are many places where pyrogen can lurk undetected!

What is a pyrogen? As long ago as 1865, Billroth[1] found that distilled water injected intravenously in dogs sometimes caused fever. Burdon-Sanderson[2] in 1875 coined the term "pyrogen" which literally translated means "I produce fire." The increasing use of intravenous solutions in the next 35 years resulted in many febrile reactions. They became so commonly associated with this route of administration that "salvarsan fever," "protein fever," "milk fever," and "salt fever" were expected after the use of various substances. In 1911, Wechselmann[3] showed that salvarsan fever was not due to the drug itself but was due to the water in which the drug was dissolved. The fever could be eliminated by the use of freshly distilled bacteria-free water. Hort and Penfold[4] about this same time demonstrated that freshly distilled water did not cause reactions while the same water stored for a time, presumably open to room air, constantly caused fever. Dr. Florence Seibert[5] in 1923 conclusively showed the existence of pyrogenic substances and their bacterial origin. By carefully controlled studies, many factors previously held responsible for what we now know as a pyrogenic reaction were excluded. She clearly showed that the one factor always present in pyrogenic water was past or present contamination of that water with bacteria. The bacteria might be removed by Berkefeld filtration but the water remained pyrogenic. She showed the importance of using an efficient still, the need for sterilizing water immediately after distillation, and the resistance of pyrogen to autoclaving. She was the first to use rabbits to test for pyrogen. Co Tui[6] in 1942 showed the importance of biological testing of various chemical ingredients

Cleaning and Sterilization of Needles and Syringes

TECHNIC FOR NEEDLES

Needles should be *cleaned* immediately after use by means of a stylet and flushing with cold tap water. The needles should then be placed in a basin containing an *alkaline* detergent solution to await the following cleaning procedure:

1. Wash and rinse needles thoroughly in warm detergent solution, flushing the needle cannula with the aid of a clean syringe. Clean the inside of the hub with a cotton swab.

Note: Autoclave needles in double-strength detergent solution if they are caked with dried blood, tissue, mucous, etc., using a temperature of 250° F. for 15 minutes.

2. Soak and rinse needles thoroughly in frequently changed or running tap water, flushing the needle cannula with the aid of a clean syringe.

3. Rinse needles thoroughly in freshly distilled, nonpyrogenic distilled water to remove any impurities left by the tap water, flushing the needle cannula with the aid of a nonpyrogenic syringe. It is recommended that needles be rinsed in a small stream of distilled water so that rinsings (which might be contaminated) are discarded continually.

Note: Needles for use in blood work should be rinsed in *nonpyrogenic* normal saline if they are to be steam sterilized.

4. Place needles, *immediately after final rinsing*, in containers, plug loosely with cotton, and sterilize *immediately* in a high-pressure steam autoclave for 30 minutes at 250° F., or in a hot-air oven for 60 minutes at 320° F.

Note: It is neither necessary nor advisable to treat stainless or rust-resistant needles with alcohol or ether to dry them. Needles treated as described will be dry shortly after steam sterilization.

TECHNIC FOR SYRINGES

Flush syringe with cold tap water immediately after use, separate and place parts in a basin containing cold *tap water* to await the following cleaning procedure:

1. Place syringe barrel and plunger in warm detergent solution and wash thoroughly, flushing the barrel with the solution. Allow parts to remain in the solution at least 10, and preferably, 15 minutes.

2. Wash and rinse syringe parts thoroughly in frequently changed or running tap water, flushing the inside of the syringe barrel.

3. Rinse the syringe parts thoroughly in freshly distilled, *nonpyrogenic* distilled water, flushing the inside of the syringe barrel. It is recommended that the parts be rinsed in a small stream of distilled water so that rinsings (which might be contaminated) are discarded continually.

Note: Rinse syringe parts in nonpyrogenic normal saline if they are to be used in blood work and are to be steam-sterilized.

4. Replace syringe plunger in barrel and wrap syringe in clean muslin or other suitable material. The plunger should be inserted all the way into the barrel.

Note: The barrel and plunger may be sterilized separately in the same wrapping if desired; however, it is safer and more convenient to sterilize the assembled syringe.

5. Sterilize the syringe, *immediately after wrapping*, by autoclaving it in a high-pressure steam sterilizer for 30 minutes at 250° F., or in a hot-air oven for 60 minutes at 320° F.

TECHNIC FOR NEEDLE CONTAINERS

The technic for needle containers is identical with that for syringes.

GENERAL

It should be emphasized that the success of the foregoing operations is dependent on the *speed and thoroughness* with which the various steps are carried out, the use of nonpyrogenic final rinse waters, and the use of nonpyrogenic flushing syringes. It is also important to realize that ordinary "distilled water" may not necessarily be nonpyrogenic. Otherwise acceptable distilled water may become pyrogenic when exposed for any length of time in the laboratory or cleaning room atmosphere; consequently, it is desirable to discard final rinse waters frequently or rinse in a small stream of distilled water and discard rinsings continually. Any mechanical devices employed in cleaning needles and syringes should be cleaned thoroughly and rendered nonpyrogenic. Containers for distilled water should, of course, be nonpyrogenic. Fresh detergent solution should be made daily or oftener, if heavy loads are cleaned. Personnel charged with the duties of cleaning and sterilizing syringes and needles should be impressed with the importance of their work and be well versed in the technics involved, including proper operation of stills and sterilizing equipment.

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for pyrogen before they are used in the preparation of intravenous solutions. Some may be pyrogenic as a result of being crystallized or processed in pyrogenic water. Biologic assay is the only sure way of detecting their presence.

As a result of the work of these and many others, we now define a pyrogen as a toxic substance formed by a microorganism and capable of causing prompt elevation of temperature in animals when injected in minute (microgram) doses. Various organisms have been shown to produce pyrogen; many can multiply and produce pyrogen in as poor a medium as distilled water. Rademaker[7] in 1947 reported that the film of moisture inside a needle can produce enough pyrogen; many can multiply and pro- autoclaved promptly after cleaning. The gram-negative bacilli are of special importance because their pyrogens are very heat resistant. Autoclaving for long periods will not destroy them. Bennett and Beeson[8] in 1950 prepared an excellent summary of the properties and biologic effects of bacterial pyrogens.

Many attempts have been made to identify the substance responsible for the fever response. It appears to be a complex polysaccharide which is very potent. Two ounces properly diluted would cause fever in 150-000,000 patients. All each person would need is one drop of a 1:100,000 solution of pyrogen.

The main characteristics of pyrogen are:

1. Pyrogen is a water soluble substance derived from microorganisms.

2. Pyrogen is not eliminated from solutions or equipment by methods commonly used for killing bacteria (heat sterilization) or removing bacteria (Berkefeld filtration).

3. Pyrogen can be removed from water by distillation provided the still is efficient.

4. If such distilled water, or clean, moist equipment is to remain pyrogen-free it must be promptly sterilized.

5. Pyrogen, and the debris in which it forms, can be removed from equipment by proper, but exacting, cleaning methods.

Because of the hospital experiences reported here, we recently asked 15 hospitals selected at random to tell us how they cleaned their needles and syringes. At the same time, we wanted to discover how many were familiar with the pyrogen problem. Six of the 15 hospitals indicated some unfamiliarity with the problem and all showed a desire for a reliable cleaning method. In response to this, we have prepared copies of a tested procedure which is reproduced on page 104. In simplest terms, the cleaning method consists of adequate cleaning with an effective detergent, rinsing well in tap water, rinsing finally with nonpyrogenic water, and prompt wrapping and sterilizing.

It must be emphasized here that just as cleanliness isn't the same as sterility, neither does sterility mean freedom from pyrogen. All that is sterile is not nonpyrogenic. Nonpyrogenic technic includes, but is something more than, an aseptic technic. It is essential that this last fact be understood by all who seek to prevent pyrogenic reactions. Today, the aseptic ritual of the operating room is accepted and practiced throughout the surgical world. It should be our goal to establish the more complicated nonpyrogenic technic as an equally important ritual in all aspects of parenteral therapy. It is up to all of us with scientific training and experience to keep alive the knowledge of pyrogen and how to exclude it. Consult with responsible individuals to the end that the person whom we all serve, namely, the patient, can be completely protected from the unnecessary experience of a pyrogen reaction.

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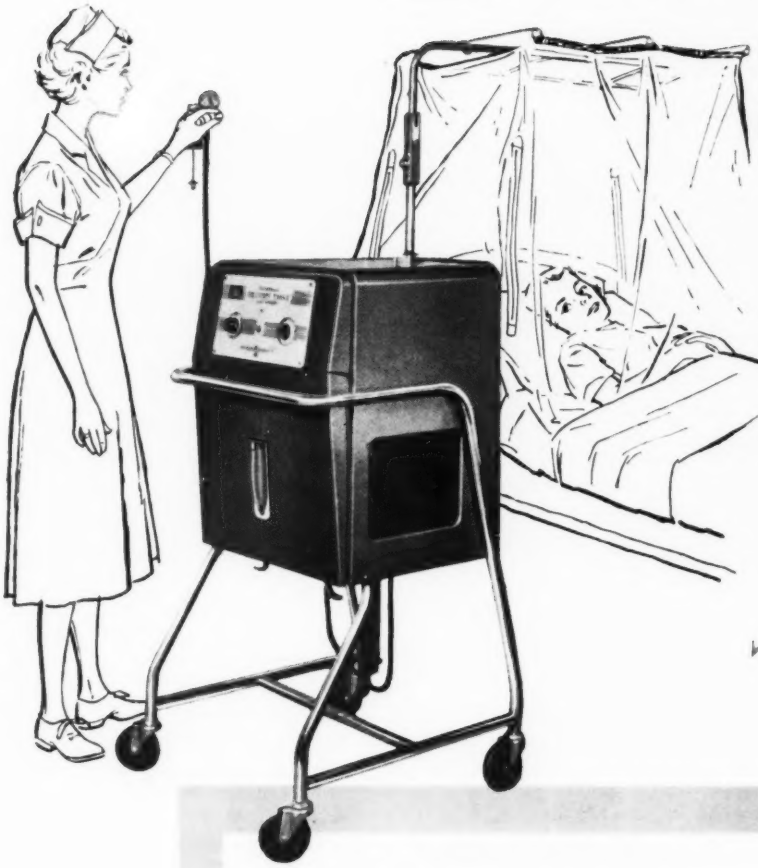

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The Goal Is a Model Dietary Department

How one hospital operates to achieve the purpose of making the food service contribute to better patient care

JOHN F. WIGHT and SYLVIA R. MITCHELL

Respectively, Assistant Administrator and Chief Dietitian
Herrick Memorial Hospital, Berkeley, Calif.

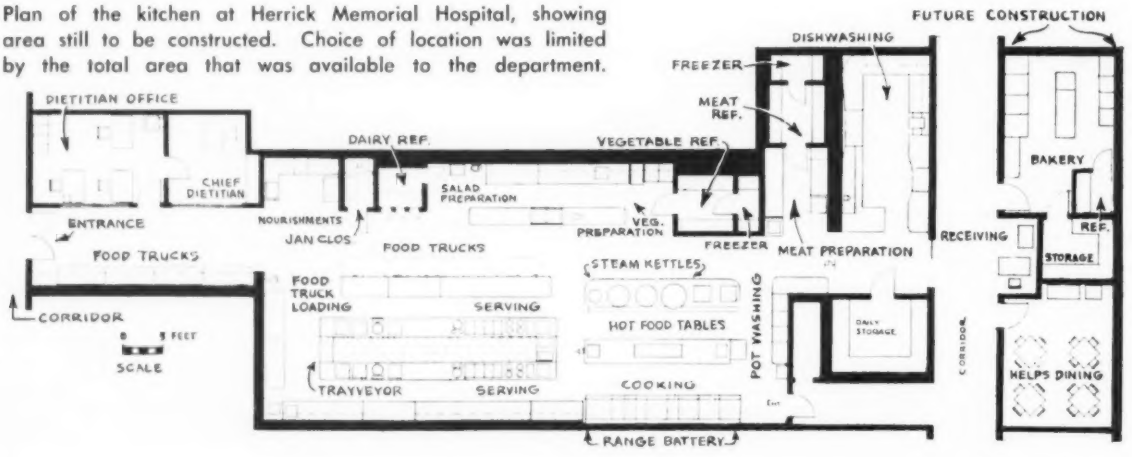
THE dietary department of today's hospital is a large complex organization which has progressed to its present status from a small and somewhat insignificant auxiliary department. During this growing stage we have seen the responsibility for food preparation pass from the chef or nurse to the well trained dietitian. The dietitian has, therefore, become a member of the "management team" with the inherent responsibilities of labor and food cost, personnel management, consultant on kitchen construction and equipment, and a variety of other duties in addition to the primary one of food preparation. This responsibility has been summarized in the statement: "Management is the art and science of organizing, preparing and directing human effort applied to control the forces and to utilize the materials of nature for the benefit of man."* Such is the dietitian.

Now, if one were to ask a hospital administrator what he considers to be the model dietary department, he might answer: "I want the most modern and efficient equipment, a capable dietitian to manage the department, efficient personnel, good food preparation and service, one which can completely fulfill the requirements of my medical staff, make all patients happy, all at the lowest possible cost to me." Assuming these to be the requirements of a good dietary department, we then proceed with establishing our department.

*Adopted in 1921 by the management division of the American Society of Mechanical Engineers.

Fortunately, Herrick Memorial Hospital, Berkeley, Calif., recently had to replace an obsolete kitchen which, because of problems evolving from the physical limitations, made it difficult to meet many of the requirements of a model department. As a 201 bed nonprofit general hospital with approximately 500 medical staff members and 400 employes, the demands on the dietary department were such that not only was a new kitchen required, but it had to be designed ultimately to render food service to a 350 bed hospital, since that is the immediate goal of this institution as to size. In addition, ours is a teaching hospital with approved schools for interns and residents, x-ray and laboratory technicians, medical record librarians, nurse's aides, and affiliations for

Plan of the kitchen at Herrick Memorial Hospital, showing area still to be constructed. Choice of location was limited by the total area that was available to the department.



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Serving counter of the combined cafeteria and coffee shop, which is also open to the public. The cafeteria is presently located on the main floor of the hospital, above but not over the kitchen.

Eating is a democratic process at Herrick Memorial. Professional and nonprofessional personnel share the dining area.

physical therapy students, and psychiatric nurses.

The planning of a new kitchen required, as the first step, the selection of a suitable site since the existing kitchen could not be adapted to facilitate a larger department. Our choice of location was limited by the total area available for allocation to the dietary department and to other hospital units yet to be expanded. Consequently, we acquired a long rectangle, irrevocably shaped by the old building on the one side and the new wing on the other, as the only area left that was suitable for the kitchen.

STANDARDS NEEDED POLISHING

Having spent the last four years in planning for, constructing and inhabiting a new kitchen, little time was left for us to polish our food service to the standards we desired. Numerous strikes by various unions in this area, two of which were directed toward organizing our hospital, have complicated our progress. More time has had to be allocated to scheduling employes in the various jobs as classified by union regulations, and likewise in making out the pay roll so that each employe is paid at the rate set by union contract for the particular job or jobs he has been assigned. Consequently, we have had to readjust working procedures in the dietary office to meet these extra duties, leaving us less time to check other phases of our department.

Three dietitians and a secretary comprise our diet office staff. Our eager and hard working group includes an administrative assistant, therapeutic dietitian, and the secretary-bookkeeper Thirty-seven employes staff the kitchen and cafeteria-coffee shop. Of these, 10 are part-time students from the University of California and local high schools.

The hospital's proximity to the University of California campus has given us a reliable source of workers. On the straight-shift 40 hour week adopted for all hospital personnel about six years ago, we have been able to arrange the work schedules effectively with the help of these responsible employes. Our full-time persons are scheduled to cover breakfast and noon food service, and our part-time employes, supper meals and week ends. One or two full-time workers supervise these students. In this way we prevent wasteful overlapping of the early and late shifts.

We utilize a centralized tray service for most of the patients' meals. The exception is the 24 bed psychiatric unit in which family-style food service becomes an important part of patient therapy.

To feed employes and house staff, we have established a pay cafeteria-coffee shop which is also open to the public. The unit is at present inconveniently located on the main floor of the hospital, above but not directly over the kitchen.

To administer these various areas of service we have divided them into three parts: the main kitchen, the cooking unit, and the cafeteria-coffee shop. The assistant administrative dietitian is responsible for the main kitchen. She supervises and schedules all employes in this area. In addition, her duties include checking daily stores, ordering food and supplies, except meats, and planning meals for patients. Under her direction, we have a competent kitchen supervisor who assists in expediting the planned work schedules by seeing that basic procedures are followed, that the tray line is ready to function on time, and so forth. She relieves us of many small details at the busy time just before meal service. Also, she is responsible for covering the kitchen when other dietitians are not on duty. The therapeutic dietitian's duties will be discussed in a subsequent article.

RESPONSIBLE FOR EMPLOYMENT

The cooking unit and the cafeteria-coffee shop are under the supervision of the chief dietitian. She makes out schedules for these employes, and plans menus for the cafeteria adapted from the patient menus. Besides these duties, she is responsible for employment and dismissal of all personnel within her department, initial orientation of all new employes, teaching job procedures to employes in the cafeteria-coffee shop and cooks' unit, meat ordering, supervising social activities, making out and evaluating reports and records, and determining specifications for equipment and supplies.

For the last six years we have operated a coffee shop open to the

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ONE CONVEYOR, MANY TOP ARRANGEMENTS — The Blickman "Selective Menu" Food Conveyor has been specially designed to provide a variety of foods for selective menus. It is built entirely of stainless steel. Square and rectangular pans, furnished with each conveyor, can be arranged in different ways within each of the two rectangular wells. Combinations can be varied according to the food requirements for any given meal. Since it transports food in bulk, fewer trips are required, reducing elevator use considerably during mealtime.

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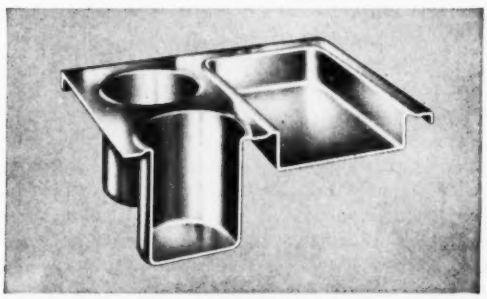
CHOOSE the top deck arrangement needed for any specific menu. Variety of sizes in square and rectangular insets permits flexibility in accommodating a number of vegetables, meats, fish, potatoes, soup and broth.



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"Selective Menu" Food Conveyor at Stamford (Conn.) Hospital. Nurses carry trays from diet kitchen to patients with food that is hot and appetizing.

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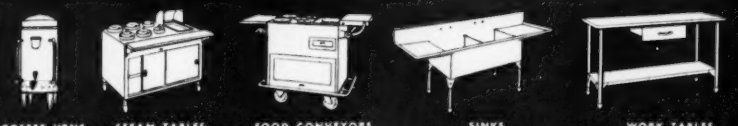

See the Catalog of Blickman-Built Food Conveyors in the Hospital Purchasing File

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public and employes. The menu was simple—cold sandwiches, fountain items, soup from the main kitchen during meal hours, and hamburgers and hot dogs. Those employes wishing a hot meal could purchase one from the old kitchen which had a small dining room adjacent. Students were fed here also. Owing to our crowded quarters, patient meals were served first, and then the staff, utilizing the same tray line. We sometimes had difficulty meeting deadlines for this latter service when our patient count was high. With our new kitchen, which was finished in 1952, and with relocation of the cafeteria to a near-by classroom, this problem had been solved.

Last spring we incorporated the cafeteria and coffee shop into one unit. By expanding our counter a few feet and adding an electrically heated bulk food cart we were able to serve hot meals, including breakfast, from this area. Tearing out walls and reconstructing others, we utilized the old kitchen space which was located behind the coffee shop for additional and much needed dining rooms. This unit will suffice until our permanent and larger cafeteria can be built.

The concentration of the nonpatient meal services into one unit has enabled us to feed more persons more efficiently. The cafeteria offers self-service for all hospital personnel and doctors. Everyone, including our administrator, brings his own tray back for scrapping. Two carts located near the exit hold the used trays to be returned to the kitchen downstairs for washing. Everyone seems to accept this democratic system. A separate dining room for doctors allows them to converse privately without disturbance from the public.

STUDIED MEAL COSTS

The main problem we faced in establishing this service was in combining cash customers with students who receive meals as part of their compensation. By trial, the simplest solution was to allow the students to select whatever they wished. In a study carried over a period of 112 days, the cash register girl recorded the cost of their choices for each meal. By keeping careful records we found on the average that students ate about 27 cents more per day than their allowed $1.50. We felt that their satisfaction with the food service in being able to select whatever they desired justified this additional expense. We are continuing to record their meal cost so each will realize the value of his selection. (A University of California student in our employ wrote a complete paper based on this group as part of her psychology course requirement for a statistical study, which is another advantage of this source of employment.)

In complying with standards for a food service which offers the best as economically as possible, we have established competitive buying procedures. As an emergency hospital, which serves several communities, we also find it good public relations to distribute our business as widely as possible. For example, our dairy products are divided among several companies: eggs and butter from one, liquid milk products from another, ice cream from a third, and cheeses from a fourth. We are free to change these purveyors at any time.

For buying meats, which represent one of the highest expenditures of our budget, we also purchase from four different companies. Once a week, after the menus are planned, a sheet is prepared listing the cuts of meats needed for the following week, and the grades or quality are carefully stipulated. Then price quotations from each company are obtained by telephone. Final selections are based on price as well as quality, and on experience of the type of service these purveyors offer. We have found wide variances in prices for the same quality cuts, as much as 25 cents per pound. Obviously, the best method for proper meat selection is to see what you are buying, but since many of us do not have time to market in this way, this is a satisfactory procedure. Visiting each of the companies to view their operations has also helped us in establishing our standards. Constant checks are necessary, however, to be sure the meats delivered to us are the quality and quantity we ordered. The cooks are responsible for weighing in and checking meat deliveries.

Similarly, on a smaller scale, produce is purchased. From two companies, one of which is located just a block from our hospital, we obtain competitive prices. The convenient location of this one seller from a large retail grocery store enables us to inspect items before we buy. Also, they allow us to purchase in small quantities at wholesale prices foods often needed for special diets.

Even our bread, a set price item, is purchased from two companies—whole wheat from one and white (a special high protein loaf tested through a Stanford University study) from another.

Certain areas around the new kitchen have yet to be constructed. The main loading platform and elevators are just being built, so eventually deliveries will be made as indicated by the floor plan. We hope to designate the kitchen supervisor to check in all supplies as they are received into the department. At present, certain employes are responsible for delivery inspection: the vegetable man under the cook's direction for produce, the employe who serves butter and cream for dairy products, the daily storeman for general store requisitions, and the assistant administrative dietitian and kitchen supervisor for all other deliveries. Nonperishable supplies are requisitioned three times weekly from the centralized purchasing department. We receive the duplicate copy with the cost of each item listed.

THE MOST DIFFICULT JOB

Perhaps the most difficult administrative job is the one of evaluating people. To be able to interview an individual for a short time, and be reasonably sure he will adjust harmoniously into your group, and also be capable of performing the job, is an enviable trait. The need for reliable aptitude tests which can be readily evaluated by personnel directors or employers is certainly acute. We are fortunate in having an excellent and cooperative personnel director who helps screen applicants, orients new employes to the hospital, and gives basic instruction on hospital policy and regulations. Through him we are attempting to set up written tests and performance skills. We hope to invite encouragement from the University of California and Stanford University. Although unions stipulate job classifications and corresponding rates of pay, they have done little to evaluate their members on the basis of skills required and desirability. We therefore find we must screen these applicants as closely as we screen other sources of employe procurement.

Once an applicant is hired, he is given a physical examination which includes laboratory work, chest x-ray examination, and a general physical conducted by the resident doctor. Chest x-ray tests are repeated annually, the

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3. Modern streamlined design. Durable finish of nickel and chromium will stay bright for years.
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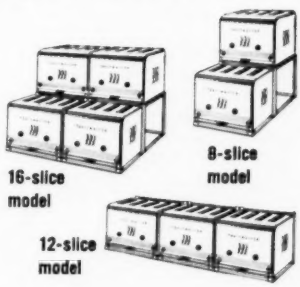

NOTE: VISIT-YOUR-DEALER WEEK is September 20-25. It's "open house," so stop in and get acquainted!

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employe being notified by the personnel department which keeps a file on each individual.

We make it a policy to establish friendly relations with our personnel from the beginning. We see to it that each one is given a personal introduction to other employes or, if time does not permit of this, the kitchen supervisor helps new employes to overcome their apprehension toward a strange environment. Someone is always assigned to take them to lunch and to work with them during the first day or so until they are familiar with the outlines of their job.

A job description and analysis has been completed for every work phase of the kitchen and cafeteria. This project was finished before the new kitchen was occupied. Although we found changes were necessary to comply with the actual situations, we think it invaluable particularly in some of the part-time positions which evidence a higher turnover rate. Supervision is made easier when responsibility is pinpointed through these job directions. Every new employe is given his own copy after first going over the procedures with the dietitian. In addition, we have written a general policy for our department which expresses the habits and sanitary procedures required to maintain our standards. The employe is informed of these principles before he begins to work. These regulations emphasize neat personal appearance, proper shoes for safety, sanitary procedures for handling foods and china, and so on.

Kitchen meetings are held whenever desirable, and when time permits, to clarify the many problems and procedures that arise in any food service. As another source of communication, movies are utilized whenever we can find one specifically related to our purposes. Blackboards become valuable aids for short notices and reminders. We have them placed in several areas of the kitchen, in the serving area, cooks' unit, and in the dishwashing room.

Posters become another source of education and learning for employes. The problem of chipped china in the dishwashing room, because of the energetic efforts of our younger part-time employes, was partially solved by a poster phrased in their vernacular. It pictures an analysis of the various types of cracks in china and their causes, as well as stating the cost of replacing each piece.

One of the most effective means of shedding light on a dietary department operation is food cost accounting. To facilitate collecting figures for the monthly reports, we keep daily record of food cost. Two main reports are compiled, one for the cafeteria-coffee shop and one for the patient meal service.

COOKS RECORD QUANTITIES

The cafeteria hot food menu is typed for each week. Space is allowed for the dietitian to indicate the number and quantity of servings that will be required for each item, and purchases are based on these quantities. The cooks record, on this same sheet, the quantity of food sent to the cafeteria and the amount returned. (In this way we quickly discover what items are popular in the cafeteria.) The cafeteria girl requisitions other daily foods required from the main kitchen so we have a complete record of foods served. Deliveries from the general stores and for certain foods, such as ice cream and fountain sirups, are made directly to the coffee shop. Monthly inventories of these items are taken. Meal count records for the cafeteria are computed by dividing cash ring-ups by the arbitrary figure of 65 cents. By adding this to the number of students coming in for meals, we can determine meal costs fairly accurately.

Patient meals are easily computed by counting the tray cards before each meal service and adding to this figure the number of nourishments divided by four.

Cost for social activities is recorded separately. The difference between the foods and supplies used for the cafeteria-coffee shop and social activities represent the patient meal cost. The revenue for patients' meals is derived from an allocation of the daily room and care charge.

Although our dietary department is operated in the manner we have described, it does not meet our ultimate expectations owing to physical, financial and labor limitations. We anticipate adding better methods of personnel recruitment, more satisfactory facilities for employe group instruction, also a bake shop, and a larger cafeteria to improve our food service.

Realizing that the one indisputable goal of our institution is service, we have established this as a solid foundation upon which all activities of the dietary department are built.

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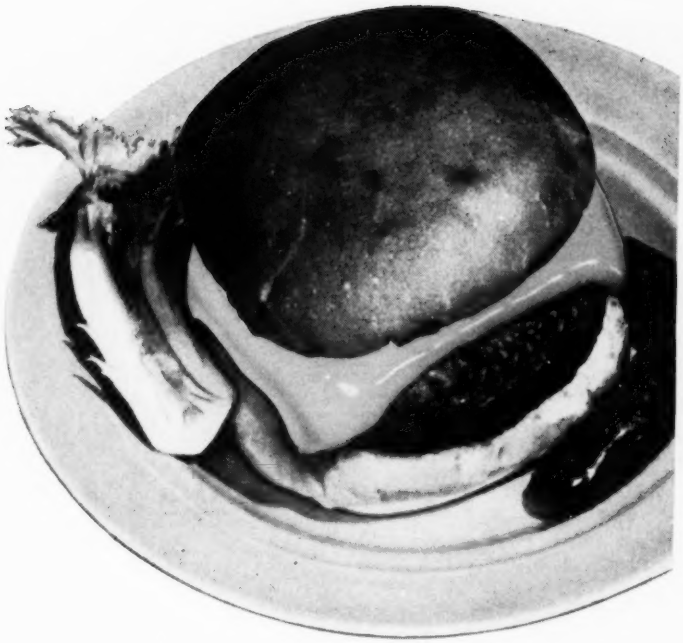
portion-controlled
profitable
cheeseburgers

Kraft Ribbon Slices



SAVE COSTLY LABOR TIME,
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ASSURE YOU
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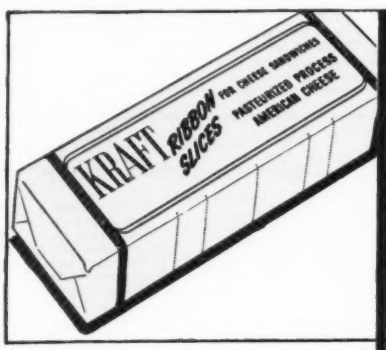
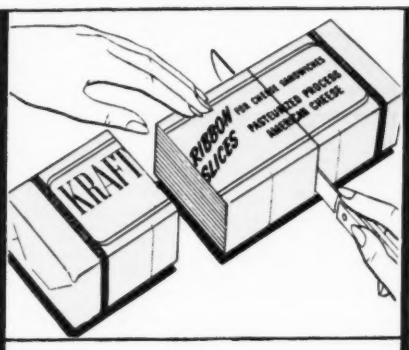
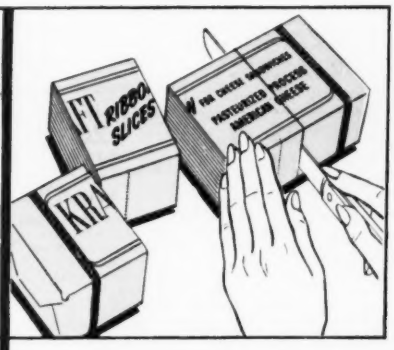


The pasteurized process cheese in this package is actually made *in slices* by Kraft. These slices will not break . . . can be lifted off the pack "just like peeling a banana."



Inside the wrapper are sixteen 10½-inch slices. With two knife cuts on the blue dotted lines on the package you get 48 *sandwich slices*—each weighing exactly 1 ounce.



Use the red dotted lines to cut 64 *cheeseburger slices.* With only three knife cuts you get slices that weigh exactly ¾ of an ounce . . . that melt perfectly without running onto the grill.

Menus for October 1954

Sister M. Susanna, C.S.J.
Director of Nutrition
St. Joseph's Hospital, Wichita, Kan.

1 Grapefruit Sections Pancakes, Sirup • Fried Rose Perch With Tartare Sauce Escalloped Potatoes Hot Pickled Beets Banana, Orange, Grape Salad Apple Pie • Salmon Potato Chip Casserole Buttered Green Peas Tossed Vegetable Salad Greengage Plums Vanilla Wafers	**2** Applesauce Scrambled Eggs, Roll • Roast Beef Franconia Potatoes Buttered Carrot Strips Cabbage, Pineapple and Marshmallow Salad Fresh Plum Cobbler • Cream of Vegetable Soup Toasted Bacon and Cheese Sandwiches Buttered Lima Beans Sliced Tomato Salad Fresh Fruit Cup	**3** Orange Juice Bacon, Raisin Bread • Roast Turkey, Gravy Sage Dressing Baked Squash Daisy Salad Chocolate Ice Cream • Chicken à la King Stuffed Baked Potato Buttered Green Beans Assorted Relishes Pineapple Upside Down Cake	**4** Apricot Nectar Scrambled Eggs, Muffin • Roast Pork, Gravy Mashed Potatoes Buttered Apple Slices Orange Coconut Salad Peppermint Tapioca With Cherry Garnish • Chop Suey on Chow Mein Noodles Tossed Vegetable Salad With French Dressing Boysenberry Cobbler	**5** Stewed Prunes Coddled Eggs, Toast • Breaded Veal Chop Mashed Potatoes, Gravy Buttered Asparagus Lettuce Wedge, Hard Egg and Tomato Slice With Mayonnaise Baked Apple • Creamed Chipped Beef on Cornbread Buttered Peas Cabbage, Green Pepper Slaw Fresh Fruit Plate	**6** Pineapple Juice Pancakes, Sirup • Beef Stew Diced Boiled Potatoes Buttered Carrots Jellied Waldorf Salad Strawberry Sundae • Hamburger on Bun Stewed Tomatoes Assorted Relishes Blueberry Pie
7 Grapefruit Sections Bacon, Cinnamon Toast • Beef Roast, Gravy Mashed Potatoes Steamed Cabbage Spiced Peach Cottage Cheese Salad Date Bars • Biscuit Meat Rolls, Gravy Harvard Beets Tossed Vegetable Salad, Oil Dressing Baked Raisin Custard	**8** Stewed Apricots French Toast, Sirup • Salmon Croquettes, Parsley Sauce Escalloped Potatoes Buttered Spinach Golden Glow Salad Lemon Pie • Cream of Asparagus Soup Toasted Cheese Salad Sandwich Buttered Wax Beans Sliced Tomato Black Walnut Ice Cream	**9** Sliced Banana Poached Egg, Toast • Meat Loaf, Gravy Browned Potatoes Creamed Corn Coleslaw Creamy Rice With Lemon Sauce • Escalloped Ham and Eggs Baked Potato Buttered Peas Tomato Wedge and Cottage Cheese Salad Fresh Pear	**10** Sliced Orange Sausage Links, Toast • Stewed Chicken and Noodles Buttered Mixed Vegetables Sunflower Salad Pineapple Parfait Pie • Fried Ham With Gravy on Hot Biscuits Buttered Asparagus Fresh Pear and Grated Cheese Salad Marble Cake	**11** Peach Nectar Poached Egg, Toast • Chicken Fried Steak Mashed Potatoes, Gravy Buttered Beets Stuffed Prune Salad Chocolate Pudding With Whipped Cream • Sausage Patties Baked Beans Tossed Vegetable Salad With Mayonnaise Fresh Fruit Plate, Date Cookies	**12** Kadota Figs Soft Cooked Egg, Muffin • Roast Pork, Gravy Cinnamon Apple Mashed Potatoes Whole Kernel Corn Perfection Salad Coconut Dream Bars • Vegetable Soup Omelet, Creole Sauce Baked Potato Assorted Relishes Maple Nut Ice Cream
13 Grapefruit Sections Bacon, Raisin Bread • Sautéed Liver, Bacon Mashed Potatoes Buttered Wax Beans Asparagus, Pimiento Salad With Dressing Orange Tapioca • Chicken à la King on Toast Points Buttered Peas Pear, Grape and Marshmallow Salad White Cake With Chocolate Icing	**14** Tomato Juice Scrambled Eggs, Roll • Grilled Pork Chop Creamed Potatoes Buttered Apple Slices Cottage Cheese in Lime Gelatin Salad Pineapple Pie • Turkey Royal With Cheese Sauce Buttered Green Beans Grape and Banana Salad Jelly Roll	**15** Stewed Prunes Pancakes With Sirup • Fried Codfish, Lemon Escalloped Potatoes Succotash Sliced Orange and Watercress Salad Cherry Pie • Tuna and Noodle Casserole Stewed Tomatoes Tossed Vegetable Salad With Mayonnaise Peanut Brittle Ice Cream Sugar Cookies	**16** Sliced Banana Soft Cooked Egg, Toast • Salisbury Steak, Gravy Mashed Potatoes Steamed Cabbage Apple and Grapefruit Salad Peach Upside Down Cake • Breaded Veal Cutlets Baked Potato Whole Kernel Corn Red Bean Salad Fresh Fruit Cup	**17** Grape Juice Bacon, Cinnamon Roll • Baked Ham, Pineapple Parsley Potatoes Buttered Peas Banana and Peanut Butter Salad Strawberry Ice Cream • Chicken Salad French Fried Potatoes Buttered Asparagus Butterfly Salad Brown Sugar Cake With Caramel Icing	**18** Applesauce Poached Egg, Biscuits • Meat Loaf, Brown Gravy Diced Boiled Potatoes Creamed Corn Coleslaw With Pimiento Chocolate and Vanilla Pudding • Cream of Tomato Soup Cheese Rabbit on Toast Green Lima Beans Deviled Egg Salad Fresh Grapes
19 Stewed Prunes Soft Cooked Egg, Toast • Smothered Steak, Onions Mashed Potatoes Buttered Carrots Waldorf Salad Lemon Cottage Pudding • Vegetable Soup Club Sandwiches Potato Chips Pear and Grape Salad Butter Brickle Ice Cream	**20** Pear Nectar Scrambled Eggs, Muffins • Roast Beef, Gravy Mashed Potatoes Cauliflower With Buttered Crumbs Molded Fruit Salad Cherry Tapioca • Vienna Sausage in Biscuit Blankets Buttered Green Beans Assorted Relishes Peach Crisp	**21** Sliced Orange Bacon, Cinnamon Roll • Breaded Pork Chop Mashed Potatoes, Gravy Buttered Pickled Beets Cabbage and Apple Salad Boysenberries Sugar Cookies • Macaroni and Cheese Stewed Tomatoes Tossed Vegetable Salad, French Dressing Chocolate Ice Cream	**22** Tomato Juice French Toast, Sirup • Fried Whiting, Tartare Sauce Creamed Potatoes Buttered Spinach Grapefruit and Orange Salad Apricot Pie • Cream of Celery Soup Creole Cheese Soufflé Baked Potato Assorted Relishes Fruited Gelatin With Whipped Cream	**23** Orange-Grapefruit Juice Poached Egg, Toast • Pork Roast, Gravy Mashed Potatoes Buttered Peas Cinnamon Apple Rings Butterscotch Pudding With Baked Meringue • Vegetable Soup Italian Spaghetti Hard Egg Salad With Mayonnaise Fresh Fruit Plate	**24** Sliced Banana Bacon, Nut Roll • Fried Chicken, Gravy Mashed Potatoes Green Beans Pineapple and Grapefruit Salad Lime Sherbet • Cream of Mushroom Soup Sliced Ham Stuffed Baked Potato Pear, Prune and Pecan Salad Gold Cake
25 Stewed Apricots Scrambled Egg, Muffins • Boiled Beef Baked Noodles Buttered Peas Red Cabbage Salad Lemon Fluff • Barbecued Hamburgers on Buns Parsley Carrots Stuffed Celery, Pickles and Olives Pecan Dreams	**26** Tokay Grapes Poached Egg, Nut Roll • Smothered Steak, Gravy Mashed Potatoes Buttered Lima Beans Perfection Salad Peach Tapioca • Chicken Noodle Soup Cold Cuts and Sliced Cheese Sliced Tomato Salad White Cake With Cherry Icing	**27** Sliced Banana Sausage, Cinnamon Toast • Roast Beef, Gravy Mashed Potatoes Creamed Celery Cinnamon Pear Salad Chocolate Sponge Pudding • Cream of Tomato Soup Cheese Soufflé Baked Potato Spiced Peach Salad Cranberry Apple Crisp	**28** Grapefruit Juice Poached Egg, Muffins • Smothered Liver, Onions Mashed Potatoes Mexican Style Corn Molded Fruit Salad Baked Custard • Meat Pie With Biscuit Crust Buttered Carrot Strips Tossed Green Salad With Mayonnaise Tomato Wedges Fresh Fruit Plate	**29** Applesauce French Toast, Sirup • Salmon Loaf, Lemon Escalloped Potatoes Buttered Spinach Apricot and Cottage Cheese Salad Cherry Pie • Creamed Eggs and Peas on Toast Squares Pickled Beets Carrot and Raisin Salad Chocolate Cake With Caramel Icing	**30** Pineapple Juice Scrambled Eggs, Roll • Salisbury Steak Mashed Potatoes Buttered Broccoli Fruit Salad With Cider Dressing Butterscotch Pudding, Whipped Cream • Deviled Ham Roll Creamed Mixed Vegetables Lettuce Wedge With 1000 Island Dressing Sliced Peaches Peanut Butter Cookies
31 Grapefruit Half, Sausage Links, Roll, • Baked Ham, Raisin Sauce, Potatoes au Gratin, Buttered Peas, Jack-o-Lantern Salad, Orange Sherbet • Individual Chicken Pie, Buttered Asparagus, Orange Gelatin With Sliced Peach Salad, Hallowe'en Cupcake					

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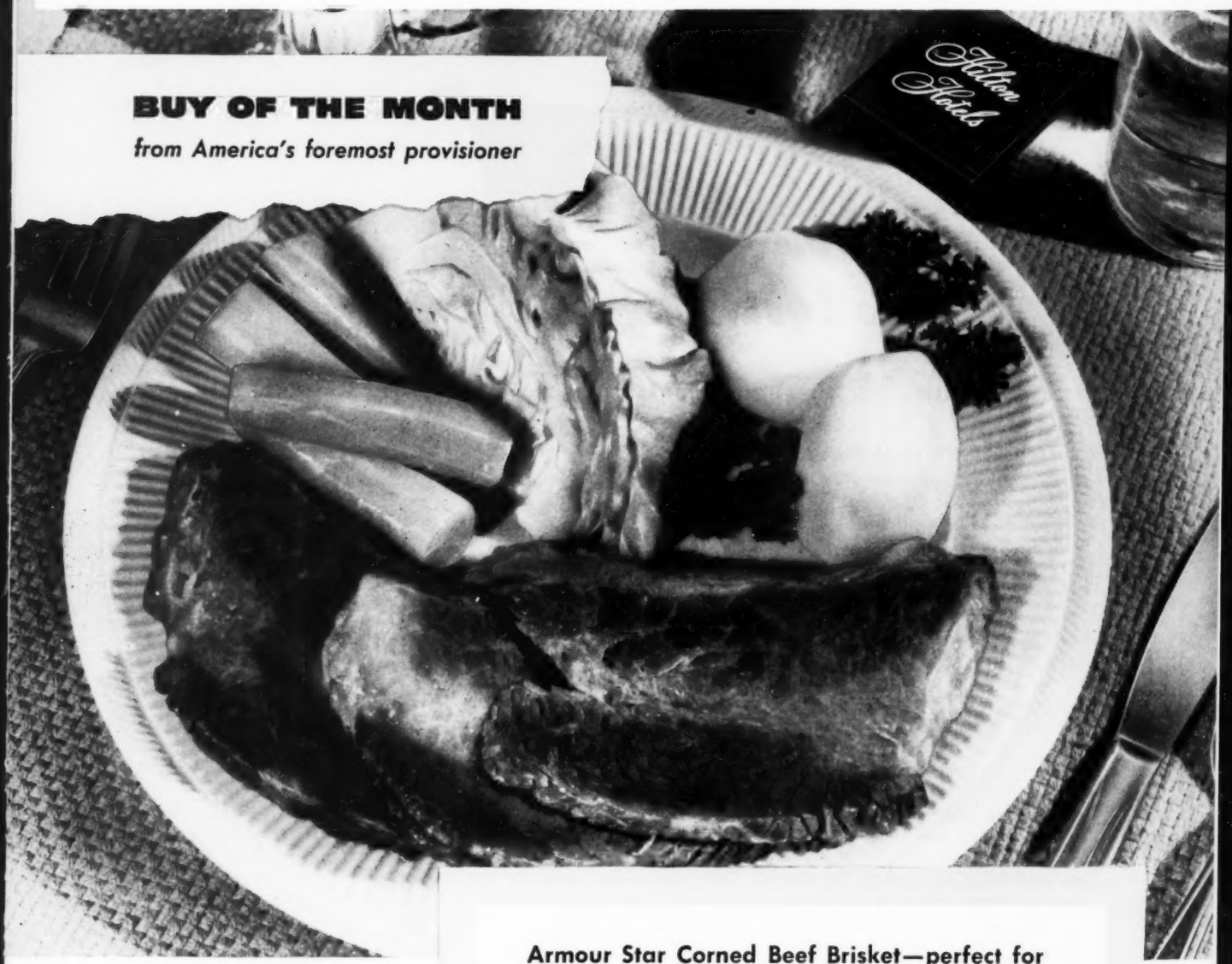

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What to Look for in the Window—

suitability for the space, ease of maintenance, reasonable cost

GEORGE BLUMENAUER
Architect-Hospital Consultant, Kansas City, Mo.

HOW should windows be evaluated relative to capital investment, operating economy and to the patient's comfort? There appears to be no one perfect answer to these questions, or to the problem of windows generally, but the results of comparative studies on various types of hospital fenestration may be of interest to hospital administrators and architects.

Usually the patient's stay in the general hospital is not of such length that the particular kind of window in his room would be a vital matter. The average acute patient probably would not particularly even notice the windows and, where service is good otherwise, the usual competitive window is usable and practical. But some window problems are met which merit evaluation for the long-term policy.

We meet the question as to what the hospital of the future may become. If we prejudge the patient's preferences, he will not select a hospital as a vacationing place; he will realize that it serves definite ends and is mainly a kind of workshop. Few, if any, aspects of the "resort hotel" fit into the hospital and the acute patient will incline to think of it as "something to endure and hope to be away from as soon as possible."

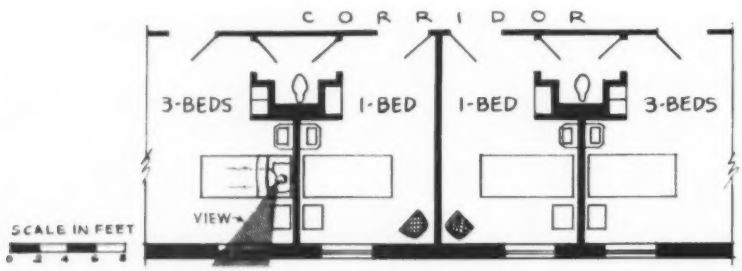
Early ambulation might be much encouraged if the patient has some inviting place to "ambulate" to — a small area convenient to the nursing section, nicely outfitted, where patients may read, play cards or checkers, or just sit and look out on a nice view through an ample window.

Where areas are set up for patient recreation, some aspects of the "resort hotel" might apply, in some degree, to the chronic and convalescent patients, whose median stay in the hospital is longer than that of acutely ill patients. But the activities of this type of patient are much curtailed, compared with those of normal individuals. Patients' rooms, treatment rooms and work areas are very practical and window planning must be approached on practical terms.

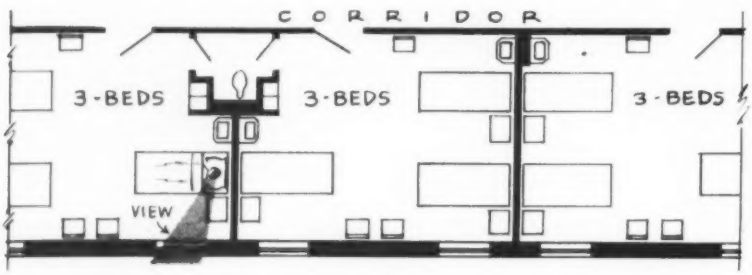
Windows, in themselves, are no unmixed blessing. The choice of window often would be predicated on unit cost, probable term of satisfactory service, resistance to corrosion, and the expected problems relative to maintenance, which include such items as reputtying, repainting, and replacement of weatherstripping, operating equipment or balances, and window cleaning.

Purpose of Windows. The main purpose of windows seems obvious, *viz.* to admit daylight, fresh air and breeze, and to allow persons inside to look out-of-doors. Were it not for these three reasons one might even question the value of windows.

The relative ease and manner of control whereby a window may be opened or closed affects its usefulness as a means of admitting daylight, fresh air and breeze; and this together with fixed types of windows and/or glass walls (windows which do not operate) which admit daylight, and windows with glass which retards thermal equal-



Schematic layouts for patients' rooms with ample window and wall space.



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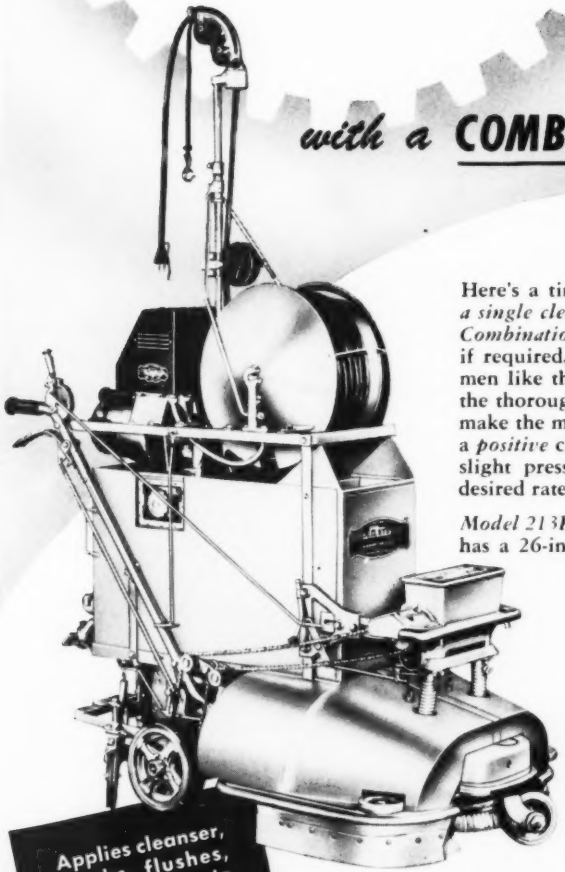

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WINDOW CLEANING COSTS[1]

	Union Labor Rate per Hr.	Cleaning Cost per Window	Work Done by	How Often Cleaned
Detroit	$2.15-2.25[2]	No. rec.		Part weekly, part monthly
Houston	1.75	$0.28	½ man	Every 3 months
Kansas City	1.82	0.15	Janitor	Bi-monthly
Chicago	2.04-2.20	No. rec.	1 man	1, 2 & 4 wks., as need
Boston	1.55-2.10	0.80		Twice yearly
Pittsburgh	1.75	0.19		Monthly
Memphis (no union)	0.93	0.30		Once every 2 months
Los Angeles	2.00[3]	0.17	Reg. empl.	Monthly

[1] Rather generous samplings were received from a number of cities and a representative segment of the result is quoted above. The wide variations shown in the tabulation seem especially interesting.
[2] $2.15 for nonscaffold and $2.25 for scaffold workers.
[3] Time and a half after 40 hours weekly.

ization between the temperature indoors and out-of-doors are the types primarily to be studied and compared for preferential qualities when windows are to be chosen for the several parts of a hospital.

There are practical needs — which may vary in different hospitals—wherein painstaking care used in window selection to obtain the most suitable type of window that is available for a given use will pay long-term dividends. The areas for which such care may be exercised with a good effect would comprise administration, storage rooms, kitchens and dining rooms, laboratories, x-ray, surgery and adjunct facilities, delivery rooms, patients' rooms, corridors, laundries, toilets, public space, mechanical rooms and sun rooms.

For example, in storage rooms with exterior exposure, the factor of security against entry and theft by way of a window is met. In the surgery and x-ray rooms we meet the question: Is natural daylighting through windows desirable at all? In public reception rooms—and possibly dining rooms—proportionately large glass areas, or picture windows, might be very desirable, especially if the outlook out-of-doors was toward a pleasing view; but if the view from the window was not pleasing, one might prefer not to have it emphasized.

Advantages and Disadvantages. Windows to permit a view out-of-doors have a beneficial effect on the morale of patients and personnel.

Exterior wall space has value in room interiors. Excessive fenestration tends to limit flexibility of partition locations, or relocations, or change in the use of affected areas in case remodeling may become necessary. Windows tend to admit excessive sky-glare, too much daylight, and nearly always must be partly obscured by light-controlling mediums in any case. Glass is very sensitive to thermal variations which cause heat loss in cold weather and heat penetration through the glass in hot weather. Excessive heat loss during cold weather must be compensated for in the heating plant. Double glazing will greatly lessen the tendency to thermal convection through the glass, but the cost of this kind of glazing is much higher than ordinary window glass.

Moisture from storms tends to penetrate to the interiors of buildings through any conceivable aperture. Windows readily become covered or streaked with dirt or other solids which contaminate the air (including excretions from human beings or animals within buildings) and thus emphasize the window cleaning problem.

Some authorities believe that careful distinction should be made when placing escapeproof or psychiatric windows in patient areas, and that "barred windows" are especially objectionable. Where it is necessary to confine criminals, or deteriorated individuals who may not expect relief or cure of their infirmity, the law naturally will expect that means to hold the committed person be reasonably assured.

For the acute patient, including alcoholics, who may expect reasonably prompt relief from the infirmity, the fact of being placed behind barred windows and escapeproof doors tends to be a psychological shock! Apparently it follows somewhat the principle described as "brain-washing" in some parts of the world and tends toward deterioration of the patient's morale. Adequate supervision of the patient seems preferable to barred windows and escapeproof doors in the general hospital.

Costs and Maintenance. The buying and installing of venetian blinds, shades and curtains or draperies is a capital investment item; replacements, painting and window cleaning are reflected in the operating budget; periodic repainting of windows made of ferrous metals or wood is necessary.

As we increase the window areas beyond the needed standards, the costs of the foregoing increase, sometimes sharply. Some of the expense items referred to may occur mostly in driblets, but the little streams that flow into the larger stream ultimately may become a mighty river.

Where the air carries a heavy proportion of soot or other combustion wastes — sometimes called "smog"— window glass will begin to show dirt film soon after having been cleaned. At some locations, under some conditions, windows are cleaned weekly. Window glass clouded with a grime film is uninviting; the larger the glass areas are the more noticeable a dirt film becomes. As the dirt film thickens the admission of light through the glass decreases in ratio. Dirt film collects and adheres on the interior surface of window glass quite as readily as it does on the exterior surface; window cleaning problems relative to both the exterior and interior surfaces should be considered.

If it is true that as Shakespeare said, "Too much sweetness cloys," it may be equally true that too much window area and glass area in hospital windows "cloys"! It seems best to avoid the faddish and to be practical. Wisdom and care in the original selection, and maintaining it over the years, are primary considerations relative to the fenestration.

The most economical window cleaning may be anticipated where the workmen can stand on the floor, inside, and perform the whole cleaning operation. For this reason, a window which can be manipulated and both sides washed from the inside seems to have much merit from the standpoint of maintenance. Relatively unskilled help can do this kind of cleaning safely. Such window types are available in wood and metal. As for window cleaning "on the inside" annoying patients, most patients are probably bored stiff, anyhow, and may welcome an occasional diversion.

Exterior window glass in multistory buildings which must be cleaned from the outside brings a problem wherein proper equipment is needed. If fixed sash are set in multistory buildings window cleaners may have to be lowered from a roof, or otherwise from above, on scaffolding to the

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A 500 bed hospital, with normal fenestration, will have approximately 800 windows. If the window cleaning average is bi-monthly at $0.15 per window per cleaning the cost is $2880 per year. Continuous fenestration—as planned in some hospitals—would sharply increase the number of windows. Also, where the unit cleaning cost is above $0.15 per window (a very low rate) the per year cost goes up in ratio. Where the cleaners must work on scaffolds suspended from above the cost is increased. There would be intangible items comprised in administration expense and probably increased insurance rates for hazardous occupation.

When selection of windows for a project is under way one should not overlook the types that are amenable to easy, economical cleaning methods. A type of window which can be opened, closed or cleaned without interfering with exterior screening, and cleaned from the inside without interfering unduly with venetian blinds, shades or draperies has advantages.

In acutely ill patients' rooms, no point in therapy seems to be gained in having window areas greater than are needed for the patients' view and comfort. As window areas are increased, usable wall space decreases, and the problems involved in controlling sky-glare and excessive sunlight, and thermal conductivity, are magnified A window strategically placed so the patient can see outside with ease, with a maximum width of about 4 feet and a minimum width of about 3 feet 4 inches, normally would meet the practical requirements for breeze or fresh air inlet and easy control of daylight.

In offices and accounting areas a window about 4 feet wide in 10 foot bays normally will provide enough glass area for good lighting during the daylight hours (under normal conditions), easy control of sunlight and sky-glare, and some wall space for other use. There can be such a thing as too much daylight. Extremely wide window openings have some objectionable features relative to control of daylight, sunshine, sky-glare and breeze, and the varying preferences of a number of individuals working in one area must be anticipated.

Windows in such work areas ought to be close to the ceiling, to facilitate light distribution to rear areas of the room or space and the probability of daytime saving in electric current for artificial lighting. Where the ceiling height is 10 feet or less, the maximum distance which daylight will penetrate effectively through clear window glass normally will not exceed 20 feet. A disadvantage with venetian blinds having horizontal slats, as usually hung, is that when the blind is raised, the top 10 or 12 inches of the window are wholly obscured, thus reducing the effective window height for admitting daylight.

Window heights above floors in nearly every case would meet practical problems and require a study of the use for which the area is intended. It is better, usually, if the bottom of the window were several inches "too high," rather than several inches "too low." If the window stool is too low, furniture or equipment placed conjunctive to it might extend above the stool, which is not always desirable.

Some day, perhaps, the perfect window will be invented and the tasks involved in window selections will thus be greatly simplified.

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Good Lighting Is Part of Good Housekeeping

basic principles of lighting and their day-to-day applications to the nonmedical activities of the hospital

RICHARD G. BOND
Associate Professor of Public Health and Health Engineer, Students' Health Service, University of Minnesota

THE presence of light is as vital to the functioning of the physical plant of a hospital as is the provision of an adequate and safe water supply, of temperature control, of laundry or dietary service. In the surgical suite and delivery room, provision is made for lighting that is adequate in quantity and quality to meet every medical and nursing need. Less obvious but equally important are the lighting needs of nearly every other activity in the hospital.

For the executive housekeeper, good lighting in the hospital is important in many ways: It helps to prevent accidents; it shows where there is dirt, or that there is cleanliness; it increases the efficiency of the housekeeping staff; it contributes to the morale and comfort of the patients, housekeeping employes and employes of other departments.

CHARACTERISTICS OF LIGHTING

In order to have good lighting and the benefits thereof, the executive housekeeper must be conscious of light and have some understanding of the characteristics of lighting. The two characteristics that are of particular importance are quantity and quality.

Quantity of light usually refers to the amount or the intensity of light on the visual task. It is measured in terms of foot-candles by means of a photo cell light meter quite similar to the type used in photography.

The amount of light necessary in various parts of the hospital can be estimated from the recommended standards that have been published for office lighting.[1]

Where the seeing task is difficult, involving fine detail and long periods of visual concentration, such as in the sewing room, the business office, or typing room, 50 foot-candles of light are recommended.

If the seeing task is average, involving only moderately fine detail, good conditions of contrast, and intermittent visual concentration, 30 foot-candles are recommended. Examples of such work areas would be the general office, conference rooms, laboratories, active files, nurses' stations, and the reading light for the patient.

Where visual tasks are casual in nature, such as hallways, stairways, reception rooms, washrooms and general storage, only 10 to 20 foot-candles of light may be necessary.

These intensities should serve only as a guide in providing light; they are not fixed quantities although they are usually considered to be minimal. These values are considerably higher than were being recommended 20 years ago and the scientific basis for recommending these and higher intensities of light has been questioned from time to time.[2]

There seems to be no doubt that visual strain is a function, in part, of the level of illumination provided; but in no sense are work performance and level of illumination simple functions. This relationship of intensity of illumination, visual fatigue, and performance has been studied by Keys, Brozek and Simonson in the Laboratory of Physiological Hygiene at the University of Minnesota.[3,4] Assuming, however, that a certain quantity of light is important for reasons of efficiency and work performance, as well as certain obvious aspects of accident prevention, the rôle of the housekeeper becomes important in many ways. In a direct way, the amount of sunlight that can enter the building through windows and skylights will depend upon the kind of housekeeping that is being done. Dirty window glass will reduce natural light as much as 25 per cent. The amount of natural light entering a room is further affected by the choice and use of blinds, shades and draperies. Window screens left on during the winter keep out 20 per cent of the sunlight when the hours and amount of daylight are already at a minimum.

Dirty light bulbs and reflectors reduce electric lamp efficiency by from 10 to 20 per cent even with a reasonable cleaning schedule. Dirty walls and ceilings decrease the reflectance values of paints by as much as 25 per cent so that adequately designed lighting systems become inadequate as a result of poor housekeeping.

The decoration plan for each specific area of the hospital must take into account the lighting needs of that area. Choice of colors and finishes for walls and ceilings should be determined, with the required reflectance value being the principal consideration.

REFLECTANCE VALUE OF COLORS

Reflectance value or reflection factor is defined as the ratio of reflected light to incident light, and it is usually expressed as a percentage. Examples of the wide range of differences in reflectance values are the following:

Flat white, 75-90 per cent
Light yellow and blue, 60-70 per cent
Ivory and cream, 55-75 per cent
Light green and gray, 40-50 per cent
Medium gray, 15-30 per cent
Medium to dark brown, 15-30 per cent
Medium green, 15-30 per cent
Red and maroon, 5-15 per cent

Reflected light is measured in terms of foot-lamberts. This term expresses

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Condensed from a paper presented at the section meeting, National Executive Housekeepers Association, Upper Midwest Hospital Conference, May 1954.

the surface brightness of an object and inasmuch as vision depends on the light's reaching the eye, reflected light is the ultimate consideration in determining the values of the previously recommended intensities of light.

The choices of color necessary to meet the usual recommended reflectances of 80 to 85 per cent for ceilings, 50 to 70 per cent for walls, 30 to 50 per cent for furniture, 15 to 30 per cent for floors are rather obvious, and somewhat limited.

The importance of color as such cannot be overlooked, but cannot be adequately discussed here. It is generally agreed that colors near the red end of the spectrum are psychologically warm and stimulating, while those near the blue end give impressions of coolness and quietness. People are responsive to their surroundings, and color is one of the chief factors that determine what those surroundings are like.

Equally as important as quantity of light is quality of light. By quality of light we mean conditions of glare and contrast.

Glare is a familiar term, and conditions of glare as a characteristic of either natural or artificial lighting are commonplace. In the hospital, office workers who have desks facing windows so that they are exposed to the glare of the direct sunlight, and the patient who is exposed to reflected glare from the shiny waxed table tops, picture glass, a glossy wall or ceiling are concerned with glare; so is the laundry or food service employe who works beside an unshielded light bulb all day long. Housekeeping personnel should be cognizant of glare so as to eliminate insofar as possible typical situations such as those just described.

Glare is "light out of place." It results from light rays that are misdirected and not uniformly distributed or diffused. Glare is light of poor composition.

Contrast as a condition of lighting is not as familiar to us; however, its importance as a characteristic of the quality of lighting is receiving more and more consideration by illuminating engineers.

To appreciate the concept of contrast it is necessary to consider first the scope of the visual field.

When we look at an object such as a newspaper the line of sight is more or less normal or perpendicular to the visual task, and for purpose of this discussion is considered horizontal. The eyes focus on the printed page. This is the visual task, or the central field.[5] The surrounding field is considered to extend about 30° in all directions from the line of sight. Outside of the surrounding field there is a peripheral field of vision extending possibly 60° up or down from the line of sight and as much as 80° right or left. This is easily demonstrated by looking straight ahead at a fixed object and at the same time noticing how far to right or left objects can be seen and recognized. It is apparent that the field of vision covers a wide area.

The importance of contrast in lighting is illustrated in viewing television, for example, where there are two conditions of contrast within the visual field. On the screen we provide for a sharp focus so that the objects on the screen are clearly defined. This is contrast that is desirable. Our ability to see depends upon a distinct difference in brightness. This is the same contrast that is provided with black type on a white page of a book. The other condition of contrast in viewing television is the one that occurs when all of the lights in the room are turned off leaving only the brightly illumi-

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nated screen. In looking at the screen our eyes also attempt to probe into the darkness of the room around the screen, because our field of vision is not confined to the visual task but also includes the peripheral area of the darkened room. This unfavorable condition of contrast has been corrected somewhat by the provision of peripheral lighting of one kind or another.

Nearly everyone who works at a desk sets up similar conditions of contrast in his office. Perhaps there is a bright desk lamp which we use without also using the ceiling light in the office, or perhaps the desk is beside a window so that our eyes attempt to focus for the light reflected from the visual task and at the same time attempt to adjust for the more intense light coming through the window.

For the patient, an extreme contrast is set up when he has the bed lamp or table lamp spotlighting his reading material and the other lights in the room turned off completely.

In general, any condition of artificial lighting or natural lighting which results in a wide difference in brightness in the visual field is uncomfortable, fatiguing and distracting to the point of causing a lack of concentration and reduced efficiency. This inability to concentrate is easily illustrated by placing a white printed page on a black surface. In a short time the observer's attention wanders from the printed material to the sharp contrast between the edge of the paper and the black background. It is that more extreme contrast which attracts his attention from the job at hand.

Limits of contrast or brightness ratios have been recommended and they do have application in the hospital situation. They are as follows:[6]

1. Between the central visual field (the seeing task) and immediately adjacent surfaces, such as between the task and a desk top with the task the brighter surface, the ratio is 1 to 1/3.
2. Between the central visual field and the more remote darker surfaces in the surrounding visual field, such as between the task and the floor, the ratio is 1 to 1/10.
3. Between the central visual field and more remote brighter surfaces in the surrounding visual field, such as between the task and the ceiling, the ratio is 1 to 10 .
4. Between sources of illumination, such as light fixtures and windows, and the surfaces adjacent to them in the visual field the ratio is 20 to 1.

With these outlined criteria for quantity and quality of light in mind, application of these lighting principles can be found in almost any department of the hospital. In the offices of the administrative personnel and at medical and nursing stations there must be sufficient light for the visual task but glare must be avoided. Uniformly distributed light, in sufficient quantity to prevent excessive contrasts, must be provided. Desk tops must be light in color to reflect light, but of such finish as to be without glare. All of the walls and ceilings within the visual field must be of such hues of color as to reflect maximum light and yet not set up conditions of contrast. Windows admitting light to the room must be so equipped as to permit the maximum amount of natural light to enter. Furniture must be so placed with respect to the windows that there are not extreme conditions of glare and contrast. Windows should be furnished with shades or blinds of such material that light can be controlled so as to have good diffusion and distribution without the amount of light entering the room's being restricted. This may call

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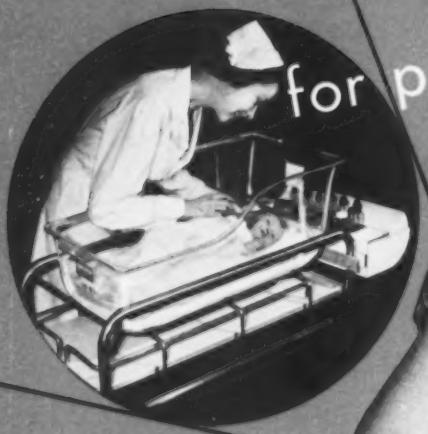

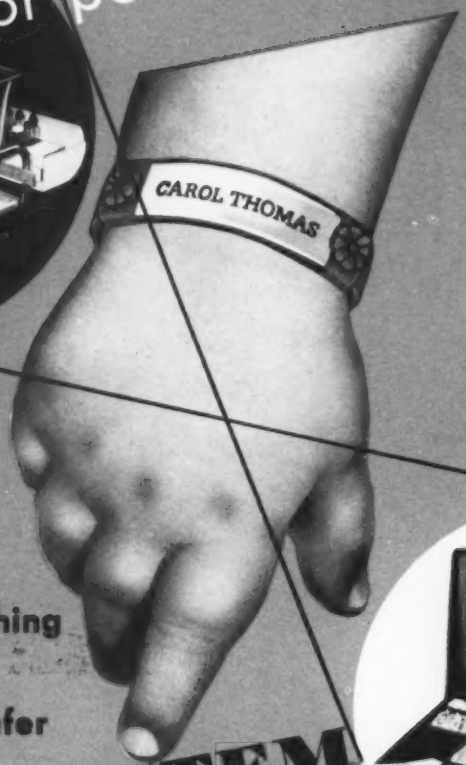

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for the use of translucent shades, vertical or horizontal venetian blinds, baffles or diffusion panels. It does restrict the use of heavy draperies. Furthermore, it is an example of the need for an intelligent choice of window furnishings to control conditions of light without, at the same time, creating time consuming and difficult cleaning problems.

The condition of lighting provided in the dietary department is important, not only from the standpoint of comfort and convenience for the food service worker, but in the maintenance of good standards of sanitation and cleanliness. A usual item in the regular food service inspection procedures concerns the quantity of light available in the various departments of the food service. Good light properly distributed in the kitchen will encourage good housekeeping practices by all concerned. Here again, conditions of glare and extreme contrasts of brightness and shadow create uncomfortable working conditions. Take a good look in the kitchen and check on those conditions where the food handler is working in semidarkness or in the glare of an unshielded light fixture.

In the storage room, particularly the food storage areas, good lighting is important as a stimulation for cleanliness, which in turn has a direct relationship to such problems as insect and rodent infestation.

The importance of good lighting for corridors and stairways should not need emphasizing but in most hospitals it is likely that situations can be found where the top of a stairway or the first step at the bottom of a flight of stairs is so poorly lighted as to create a real accident hazard. Here again, we should keep in mind the optical effect of conditions of contrast by being particularly alert to situations whereby employes, patients or visitors in the hospital may enter a darkened corridor or stairway from a brightly lighted room or the out-of-doors. We all know the experience of going into a darkened theater and the length of time that it takes for the eye to adjust to such a condition of contrast. Even where there is not contrast to this same degree, any significant change from a brightly illuminated area to one less well illuminated introduces this problem of visual adjustment and presents a real hazard during that time.

In the patient's room there are at least three different situations that must be served by the available lighting facilities. For medical and nursing care, there must be light of high intensity supplied in such a way that it can be focused on the patient in whatever manner is necessary to meet the needs of the physician and nurse. This need is usually provided for; however, it is not often recognized that this kind of illumination is not suitable for the personal visual needs of the patient.

The patient is interested in light that is suitable for reading or similar visual tasks, while being nearly flat on his back, while sitting upright in bed, or while he or his guests are seated in easy chairs. This type of visual task requires a sufficient quantity of light on the central field, and sufficient light throughout the room, properly distributed and reflected so as to avoid extreme contrasts in the peripheral field of vision. The third lighting situation in the patient's room is necessary where no visual tasks are involved, and in fact it is desirable to have only the minimum amount of light available.

In many instances, the first and third requirements have been considered, but the lighting which affects the patient most is often the least satisfactory. Obviously, a part of this problem directly concerning the housekeeper is the choice and placement of reading lamps. As simple an item as the choice of light bulb can have real significance.

In the patient's room, more than any other part of the hospital, there is need for intelligent, conscientious evaluation of both natural and artificial lighting conditions. Such related features as choice of colors and type of finish for floors, walls and ceiling and choice of ceiling light fixtures and reflector, bed lamps, table lamps and floor lamps are all of extreme importance.

Concern for good lighting in the hospital is certainly the responsibility of many departments working cooperatively and jointly with the executive housekeeping department.

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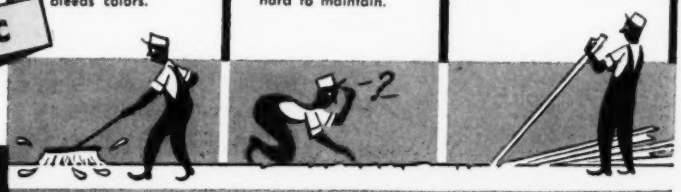

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Hospitals and the Press

(*Continued From Page* 50)

the new rules here, all information of this kind has to be obtained from our public relations office. I'll transfer your call."

In a few minutes the reporter called the surgeon back. "Public relations, hell!" he exploded. "All I learned from them was that it was a man. They wouldn't even tell me his name!"

The lesson here, it seems to me, is obvious: To be fully effective, the hospital public relations officer must interpret the needs of the press to the management of the hospital, as well as interpreting the hospital to the newspapers and the public. A hospital public relations office that doesn't do this is doing only half its job.

In spite of all your efforts, however, hospitals and doctors are still going to get a bad press some of the time. Thus you are confronted with the problem of what to do about an unfavorable newspaper or magazine article.

The first thing to do, I should say, is to keep your sense of proportion and remember that, no matter how annoying and unjust and damaging it seems, the hospital and medical worlds are not going to collapse because somebody has published an unfavorable article about them. As a matter of fact, I think we are inclined to exaggerate the importance of such articles out of their proper proportion. The other evening, I met with a group of school administrators who were all upset and concerned about the bad press that public education has been getting. "What are we going to do about all these articles criticizing the public schools?" they asked. When I pointed out that doctors and hospitals were also concerned about the bad press *they* were getting, the school people were simply astonished. They were totally unaware that any such articles unfavorable to doctors and hospitals had been appearing in the nation's newspapers and magazines. The point is that we are all naturally sensitive about articles dealing with our own activities, and we are inclined to exaggerate the importance and extent of criticism. As a matter of fact, I think the public is impressed by critical articles about doctors and hospitals only to the extent that such articles confirm actual experience. I couldn't disagree more thoroughly than I do with a recent article in a medical journal by a doctor in Phoenix, Ariz., who says, "The public has become intolerant of doctors and hospitals chiefly because of what they read in magazines and not because of personal experience." The doctor is wrong on every possible count, as I see it: In the first place, I dont think the public *is* intolerant of doctors and hospitals in any important way. Do you really think people dislike and mistrust you? I definitely do not! To the extent that mistrust and intolerance do exist, however, I should say it is due to some unfortunate experience more often than to reading. I doubt that anyone's opinion of doctors and hospitals is shaped more by what he reads than by what happens to him. This would be contrary to everything that is known about human attitudes, opinions and responses.

Unquestionably, however, there are occasions on which the hospital or the medical profession is called on for some reply to unfavorable publicity. Too many times, as I have seen them, such replies take on an aggressive, defensive tone. "Here we are, working and slaving our fingers to the bone," these replies often seem to say, "and all we get is abuse!"

Nobody is very impressed by this kind of response. The most effective reply to an untruthful article is one that points out the truth and lets it go at that. Dr. Morris Fishbein, a man who is wise and knowledgeable as an editor and publicist, had years of experience dealing with articles that were critical of him and the American Medical Association. His rule in these matters was: "Always correct a misstatement of fact. On anything else, you're wasting your time!" It's a pretty good rule.

Another kind of response that I'm sure is ignored, if not actually resented,

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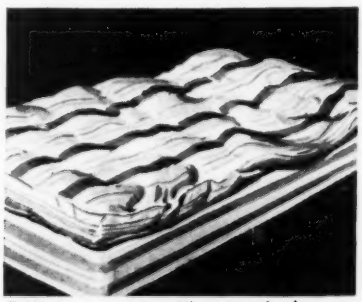

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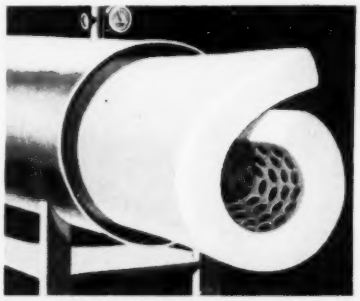

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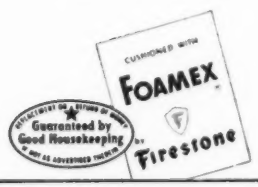

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is the one that deals in irrelevancies, answering a critical or unfavorable article by ignoring the truthfulness or untruthfulness of the criticism — or even the subject of the criticism—and saying instead, "Why don't you print an article about all the good things we do?"

I doubt that any of these responses, except those which are dispassionate and factual, has much of any effect on what appears in the newspaper and magazine press.

If there is a single technic by which hospitals, especially, might get more favorable newspaper and magazine publicity, it would be by identifying the hospital more closely with all the activities of its medical staff. The principal criticism I have of most of the hospital publicity material that I see, and I see a lot of it, is that it neglects the public's keen interest in every aspect of medicine, and tries to whip up an interest in management. By and large, management, which is your particular interest, is a dull subject. Medicine, on the other hand, is a subject of never-ending fascination for most people. The hospital public relations officer who is in close touch with all the activities of the medical staff, and the county medical society, and who knows about the clinical, investigative and educational programs that hospital staff members are engaged in, can do an effective job of getting the hospital's identity as a medical institution established in the public mind. When this is done, the need to issue defensive statements about cost, cold food and other management problems is diminished. You don't have to spend so much time convincing the public of the value of good medical care once you've established the fact that your institution provides it.

The public interest in what doctors and hospitals do is so keen, however, that articles are going to keep on appearing in the magazines and newspapers no matter what you do about it. Because most of the work you do is efficient and good, most of the articles will continue to be favorable; occasionally, however, critical or unfavorable or unfair articles are bound to appear. In the long run, I doubt that these will bear a much greater proportion to the total amount that is printed about hospitals and doctors than is justified by the number of unethical or inefficient members in your groups, compared to the total number. In short, I believe the American press is doing a good job of reporting medical and hospital news to the public, in spite of the occasional, horrible aberrations that we all deplore. Moreover, I hope that your public relations technics never become so effective that all public criticism of doctors and hospitals is withheld—desirable as this goal might seem to you now. To hold any one group or profession above public criticism would be inconsistent with the kind of society we have. If doctors and hospitals could be considered untouchable in the press, then government might be, or business, or labor, or the military, and the greatest single safeguard to our political liberty—the free press—would be lost. It is much better that we should have a press that is wrong, or even unjust, on occasion, than one which could become subservient to the interests of any group in our society.

Hospital-Patient Relationship

(*Continued From Page 54*)

One patient, a verbal self-evaluating young writer, was able to express this particular insecurity clearly. He spoke of "my own shame at being in a state of nonperfection."

A different patient put it just as strongly when she stated that she did not want visitors to see her just after her operation when she was "so completely out and so helpless."

This feeling of insecurity as an incomplete individual is ameliorated also by consideration on the part of the doctor or nurse. Such consideration by the "father" and "mother" image is forgiveness, and proof that he still is able to engender love.

Protection of the Individual. The patient therefore spends a large amount of emotional energy in both seeking assurance and in attempting to protect his mature individuality. Sixty per cent of all patients interviewed expressed the child's need for the symbolically reassuring parent together with the desire that at times they wanted some distance and privacy, some consideration for their adult status. The combined emotional need seemed often to be: "Care for me. But also respect me."

As part of this pattern of protection of the individual, 40 per cent of the patients interviewed expressed open reactions against physical embarrassments, sometimes to the point of resentment.

"The patient has to undress in the presence of the nurse and other patients. He may be willing to expose himself more freely to the nurse but becomes embarrassed in front of others. Don't have the nurse yell out to you, 'Do you want a screen?' She should be able to feel when it is needed without asking."

Another patient expressed his feelings of pain at the toilet precedures:

"People are often too embarrassed to ask for the bedpan when they first arrive. They go through hours of torture or ask the nurse for the toilet and then often get out of bed when they are not supposed to. Subject should be broached by nurse or attendant and the patient should be told where to go or where the bedpan is so he doesn't have to ask."

A third was embarrassed in a different way:

"The only unpleasant part was the immediate aftermath of the operation. I had pains for several days. Also, I was very gassy and it sometimes embarrassed me when the nurse was near. But she took it as a matter of course and thus reduced my embarrassment."

Though 40 per cent of the patients expressed some such point of view openly, more obviously felt embarrassment and did not express it. It is interesting that on this one point concerning embarrassment *all* responses were impersonal, referring to the problem in terms of "he" "they" "people" or "patients."

It was found, as might perhaps have been expected, that as the interviews drew close to the core of the patient's private and specific insecurities this tendency to masking and blocking increased. This tendency to masking highlights an observation found in the study that the large portion of openly expressed complaints, as well as compliments, about food, service and personnel, are only substitutes for deeper feelings. It is these deeper, often unexpressed feelings we must look into.

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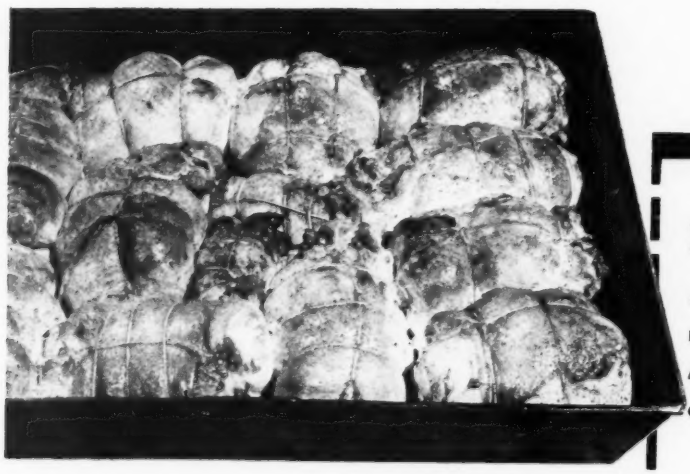

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Commission Criticizes Hospital Schools

(*Continued From Page 60*)

finest type of administrative talent. . . . The commission's chief recommendation, in consequence, is that the programs be given every form of encouragement and support by their parent schools and universities, the national foundations interested in health, and the several organizations whose activities are related to the provision of hospital care."

The commission points out that the most basic and immediate need of each of the programs is a definite statement of its objective—*i.e.* what kind of persons it wants to train, what it hopes to train them to do, and how this is to be accomplished. The following recommendations are based on a careful study of existing conditions and the considered opinion of the commission of the needs in hospital administration:

Admission Policies

1. Age limits should be fixed at 21 to 27 as soon as possible, and exceptions should be made only in extraordinary circumstances.

2. As a condition of admission to the graduate programs in hospital administration, all candidates should have completed fully and satisfactorily the basic preprofessional courses which include accounting (two semesters), statistics in administration (one semester), principles of administration (one semester), personnel administration (one semester), finance (one semester), marketing (one semester), business law (one semester), general business conditions (one semester). In discussing this recommendation, the commission says, "In preparation for the graduate professional period this commission believes there can be no question that all students, without exception, who aspire to administratorship in hospitals require fully as much foundational preparation in general business administrative study as do students planning for business and industrial management careers."

3. The experience preference of the programs should be given less emphasis and be applied in such a manner as not to discourage and disqualify too many otherwise qualified candidates. Entirely too much emphasis has been placed on previous experience in hospital work, the commission thinks. Discussing this point further, the report says, "The commission believes that the preference for experience when it results in an older student body operates to a program's disadvantage for the reason that too many otherwise qualified students are lost to other graduate schools or to business and industry, none of which refuse to accept applicants without experience."

4. The programs should promulgate in detail the attributes and qualifications they expect students to have acquired before application as well as what preparation they feel would best help the students acquire these attributes and qualifications.

5. There should be a carefully selected admissions and advisory committee composed of representatives of those academic divisions or schools concerned with the development of the program, a representative of the psychological testing service or facility of the university, and the program faculty.

6. All students admitted to the programs should be comprehensively interviewed in advance of admission, preferably at the university, by skilled interviewers. Alternates should be substituted for faculty interviewers only when the alternates are intimately familiar and have fairly frequent contact with the program.

7. Forms requesting more categorical information should be prepared by the programs for use of persons furnishing references, such forms to include particular inquiry concerning the nature and extent of extracurricular activities.

8. The programs, separately or collectively, should take immediate steps to define closely the qualifications for administratorship, in order to assist in the construction of personality, intelligence and aptitude tests specific for administrative work in hospitals.

9. All programs should be certain that their admission procedures and requirements are stated explicitly, that the programs adhere to the procedures and requirements of admission they have formulated and avoid opportunistic compromises in order to accommodate special students, and that the programs systematically record all pertinent data on applicants, students and graduates for their own and future researchers' use.

Locus of the Program

1. The program should be located in the school of business administration, provided the school affords the program not only full intellectual and financial support but also freedom to create its own standards and to experiment in its educational efforts. Commenting on this recommendation, the commission states, "Because the programs are inherently dependent, this commission is convinced that they will realize their greatest potential under the aegis of that school offering the most congenial academic environment and having the most similar educational interests and goals. It is eminently clear to this commission that the graduate curricula, teaching methods and materials and personnel of the schools of business administration most nearly approximate those herein described as necessary for the type of program, with its emphasis on management and administration, that the commission is proposing."

Curriculum

1. The graduate professional period should consist of four main areas of study: administration and policy formulation; organization and operations; analysis, evaluation, and control—all of which treat the administrative process in the hospital and other forms of organization; and environment of administration in hospitals, which provides the specific context of the process. "The curriculum proposed for the graduate professional period is predicated on the prior establishment of a foundation in general administration studies which will be a supplement to or a component of four years of broad liberal education," it is explained.

Residency Training

1. The residency period should be made an integral part of the programs. "This commission believes that the residency phase should be as much a part of the program in hospital administration as any single course

or sequence of courses in order to assure adequate preparation for administrative work." The report also points out the great importance of scrupulous selection of competent administrators, adequate plans for training them for preceptorship, and maintenance of sound lines of communication between the programs and their preceptors.

2. The programs should establish optimum qualifications for preceptorship which may be used as criteria for preceptor evaluation and training.

3. The faculty and the preceptor should develop jointly a specific plan of education for the residency.

4. No students should be permitted exemption from the residency because of previous experience or the expectation of later experience, for such action is both a denial of the integrality of the residency phase and an abridgment of the total educational process.

Teaching Methods and Materials

1. The graduate professional academic period should be characterized by a seminar approach which should not be so exclusively hospital-centered as to prevent the development of an administrative perspective based on a consideration of management problems in various other forms of organizations.

2. The amount of time devoted to field trips and visiting lecturers should be limited to that which definitely contributes to the development of administrative talent, and the time devoted to group problem solving should be increased.

3. Irrespective of the size of the student body, the classes in the program should be kept within seminar size—that is, from 10 to 15 students—in order to promote maximum group and individual development.

4. Extensive use of current publications in business and administration and management should be made by both the faculties and the students of the programs.

5. Formally scheduled class hours, exclusive of field trips and informal group activities, should be confined to not more than 18 hours per week.

6. Students should be continuously evaluated during both the academic and residency periods in order to develop each student as fully as possible and to provide data for guiding those students not equipped for administrative work in hospitals into fields more congenial to their temperaments and aptitudes. "There has been in the past very little attrition in the programs, because of a willingness on the part of the programs to carry and graduate those students not really qualified to do administrative work in hospitals," the commission points out.

Research

1. Each university program should provide opportunities to assure active participation of its faculty and students in research endeavors.

2. Each university should recognize the importance of research by providing adequate staff personnel for it or, if financial resources are not adequate at present to do so, the program and the university should earnestly seek such assistance.

3. The research activities of the various university programs should be, through an appropriate arrangement, effectively coordinated in the interest of avoiding wasteful duplication and of assuring that results derived from one research project are made available to other research projects.

Faculty

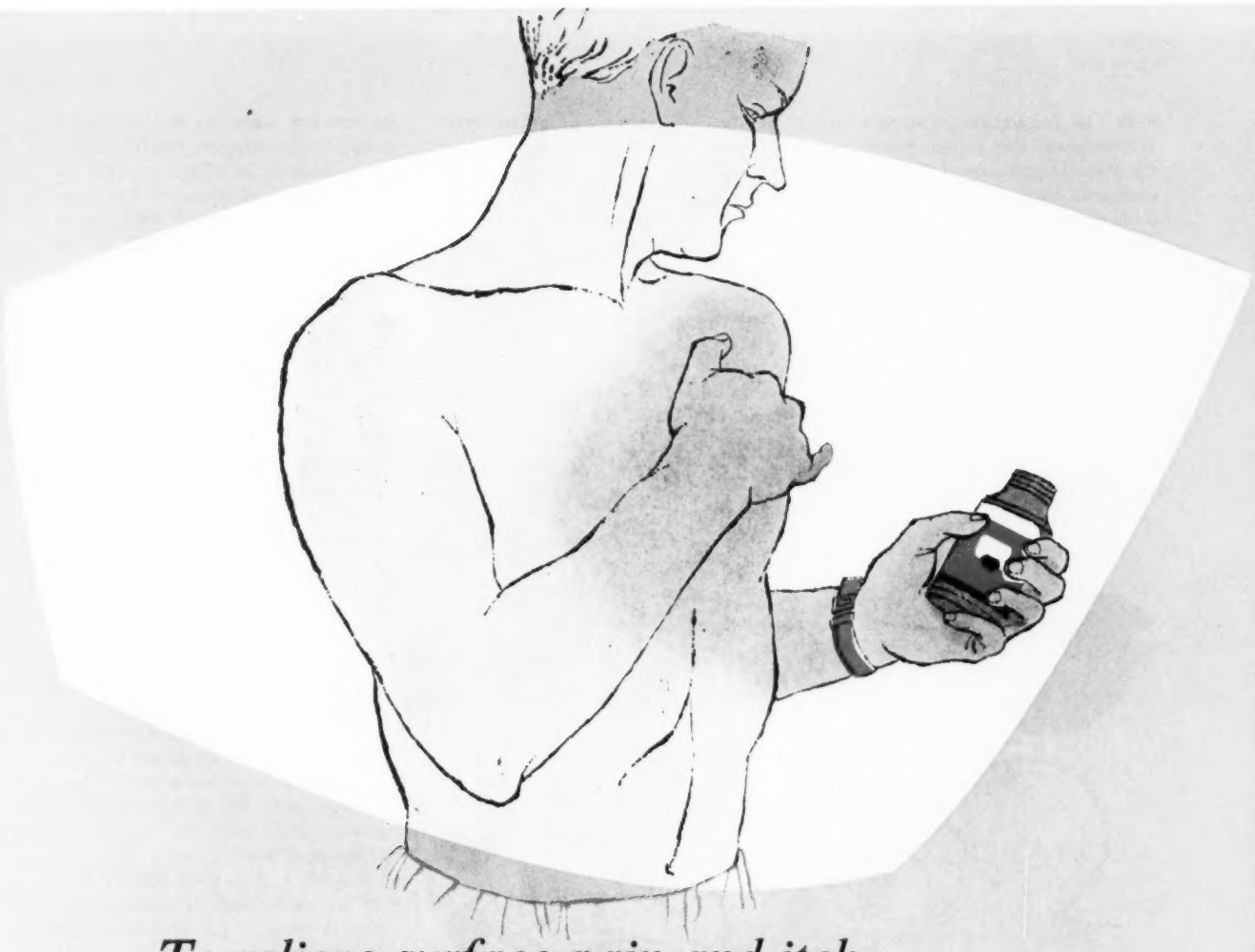
1. No program should have fewer than two full faculty positions at least one of which, preferably that of director, should be filled by a full-time person and the person or persons appointed should fulfill the appropriate qualifications with reference to education and experience as discussed in the report.

2. The programs, individually and collectively, should concern themselves now about the recruitment and training of future faculty members, actively seek students of promise, and develop the means whereby these students may profitably gain that additional education and experience which will enable them to assume teaching and research duties.

To make their greatest contributions to the students and the industry, faculty members will also have to do consultative work and participate in hospital in-service programs of varied types.

Publicity

1. All the programs should prepare their own annual bulletins, describing explicitly the objectives of the programs, the admission requirements, the content of the curriculums, and the recommended progression and development in hospital administrative



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1. Birnberg, C., and Horner, H., A Simple Method for the Relief of Postpartum Perineal Pain, Amer. J. Obst. & Gynec., 67:661, March, 1954.

2. White, C. J., A New Anesthetic for Certain Diseases of the Skin, J. Lancet, 74:98, March, 1954.

3. Peal, L., and Karp, M., A New Surface Anesthetic Agent: Tronothane, Anesthesiology, in press, 1954.

4. Schwartz, F. R., Tronothane in Common Pruritic Syndromes, Postgrad. Med., 16:19, July, 1954.

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work. In connection with this recommendation the report points out the great importance of attracting an increasing number of students of high caliber, then states: "On this publicity also depend professional and public support of the program."

2. Bulletins developed by the programs should be mailed annually to all the schools of business administration and the student counselors in those universities from which the programs accept students.

3. Continuing evaluation should be carried on singly and by group action of the universities' programs, with emphasis on proved approaches to university professional education, so as to bring the several programs to a full level with other graduate and professional endeavors within the respective universities. "The progress made by the various programs in the short span of years that even the oldest has been in operation is a tribute to the dedicated leadership they have had and to the universities that have sponsored them," the commission commented.

"Only very gradually has skilled administration come to be recognized as vital to the effective functioning of the hospital in its efforts to fulfill its greatest responsibilities to the community and to the health field and in its need to adjust soundly to varying social and economic changes," the report asserts in an opening chapter on hospital service. "There is now rather general belief that the affairs of the hospital must be in the hands of a highly competent administration if the hospital is to meet its present responsibilities and move forward to greater realization of its full potentialities for service to the people of our nation."

Tracing the history of education in hospital administration, the report points out that the University of Chicago course, now under the direction of Ray E. Brown, was the first program organized, started in 1934 under grants from the Rosenwald and Commonwealth Funds. Interestingly enough, this program was started in the school of business, thus conforming to the strong recommendation of the present commission that this is the best place for such hospital programs. Discussing the backgrounds of hospital administrators, the report states that a 1943 study showed about 40 per cent of chief administrators were doctors, 34 per cent nurses, and 26 per cent persons with other backgrounds. A similar study in 1952 showed that the proportions had changed to 33 per cent doctors, 29 per cent nurses, and 38 per cent persons with other backgrounds. The doctors were concentrated in small, proprietary hospitals, in mental and tuberculosis hospitals, and in hospitals operated by the federal government. The great improvement university courses in hospital administration will bring about in the general level of administrative ability in hospitals of the future is emphasized here.

Conclusions about the characteristics of hospital administration should provide valuable reading for every hospital trustee in the country. Of hospital administration as a specialty the report says, "For administration in hospitals the character and content of education and training should evolve from the requirements of the position of hospital administrator itself and the qualifications needed by the individual who is to fill it. Consequently, the basis of this commission's proposed educational program for administration in hospitals was obtained from a study of (1) the character of admin-

istration itself, (2) the conditions peculiar to administrative work in hospitals, (3) the personal qualities required of the individual hospital administrator, and (4) the skills and the knowledge that the individual should develop to become a hospital administrator."

Considerable space is devoted to problems of administration and the different aspects of administration in hospitals as compared to other types of organization. Much emphasis is put on the problems arising by reason of the presence of professional people. The report states, "Even if the trustees were to delegate to the administrator authoritative control over the medical staff and thereby have clear-cut lines of authority and responsibility of a single rather than dual nature, the problems for the administrator of obtaining the wholehearted cooperation of the physicians would still require the efforts of a well trained, experienced person. It is important that the administrative people of the hospital learn early and well how to work successfully with these particular professional people. Such success requires understanding of their educational, philosophical and experiential background, not in highly detailed, scientific and technical terms and principles as is required by the physician and the scientist, but in general outlines, concepts and thinking, to provide a basis for mutual appreciation and respect. The total environmental situation for administrative work in hospitals is significantly different from that of other institutions, sufficiently so in character and degree to justify specially planned educational programs in administration in the hospitals, developed and conducted by professionally qualified teachers. Young people must be aided to recognize and to understand these environmental factors, the peculiarities of the institution and the technics involved in applying basic principles of administration within this environment and to its peculiar problems."

The commission attaches great importance to a sound undergraduate training in finance and cost accounting, statistics in administration, principles of administration, personnel administration, business finance, marketing, business law and general business conditions—all in addition to a broad, liberal education. In light of the sharp differences of opinion among representatives of the university programs which this report has brought forth, the following statement is of particular interest: "Hospital administration in the past has attracted persons from various professions, principally from medicine and nursing. The preprofessional educational requirements for hospital administration proposed here may seem prohibitive for those applicants who hold either a doctor's degree in medicine or a bachelor's degree in nursing. However, it should be recognized that if the professional academic period is to be kept on a graduate level these groups are not prepared by their concentrated medical or nursing academic training alone to participate in advance work in administration."

The professional administrators whose judgments were solicited in this study recommended that primary emphasis in the academic period be put on administration, business administration in particular, and that less emphasis be given the social sciences, medicine and public health. They also suggest that stress be placed on organization and management as it applies to a variety of institutions, with special emphasis on hospitals, and that instruction be provided in the field of public health as it applies to the hospital and the problems of its administrator, but not as it is prepared for students specializing in the field of public health.

If the various stages of education and development have been properly conducted, and if the student has been adequately selected, the commission believes, he will not consider himself a finished product upon completing his graduate course and his year of residency. Instead, he will feel a strong need and desire for several years of subordinate administrative experience in hospitals before he is willing to assume the top administrative position in a hospital of more than 50 beds. "The difficulties experienced by graduates ill-prepared for the responsibilities they assume too early have caused serious repercussions in specific areas of the country against all graduates," the commission declares frankly. "The appeal made by some programs—of top jobs on graduation in the hospital field *vs.* starting at the bottom in industry—could be a powerful influence on prospective students and could defeat the laudable desire of the university graduate programs to bring into hospital administration those persons whose motivations are

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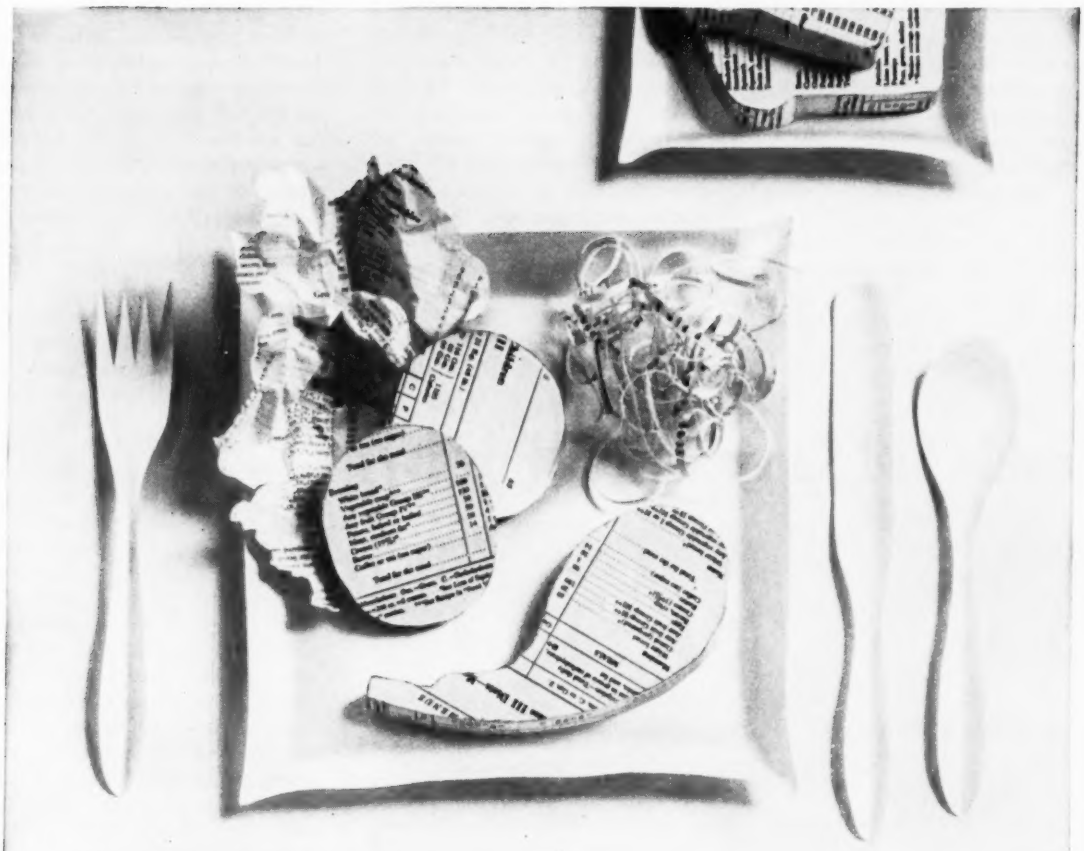

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in accord with the spirit of hospital service."

The report points out that more and more graduates must expect to start in departmental positions rather than with the top administrative group. The commission feels that the programs have not sufficiently explored this avenue of advancement for the graduates. The report also points out the great advantages to hospitals in having departmental heads and assistants of the caliber of program graduates. The development of research activity and special programs and institutes by the university courses is urged in the report.

In discussing the locus of the program within the university, the commission lays great stress on the advantages of schools of business administration. "Here is found the greatest concentration of common course contents," the report says. "Here, too, is available an insight into the broad philosophies and practices of hospital trustees." In discussing the recommendation that these graduate hospital programs can best be handled in schools of business administration, the commission recognizes that there may be other possibilities. "It is clear that there is no one perfect locus and that the program in hospital administration can operate acceptably in any of several university schools if the proper arrangements are made with the parent school and the correct people are administrative officers," the report says.

ADMISSION POLICIES

A detailed statement supporting the recommendations on admission policies and methods states, "Only persons well qualified in terms of educational background, personal traits, motivation, abilities and skill should be admitted to the graduate professional studies in hospital administration. The commission feels strongly that students admitted to the graduate program must possess as much fundamental preparation in general business administrative studies as do students planning for business and industrial management careers." In contrast to the practice in some of the current courses the commission recommends that "No specific type or amount of experience should be required for admission. Other things being equal, such as possession of the desired traits, abilities and skills, the applicant's having had some hospital experience should be given preference, if adequate evidence exists that his experience has definitely contributed to his motivation and the characteristics mentioned as desirable." Great stress is placed on motivation of the student seeking admission. "The hospital field needs what one authority on administration calls an administrative saint: the man or woman who puts himself in the service of a great function, who adapts himself to it, not altogether with regard to the monetary rewards, and gives to society rather more than he receives in terms of good management." The commission points out that this spirit prevails among many hospital leaders today.

Obviously, the commission feels that a top flight job of graduate teaching cannot be done with students varying from very young to fairly old. "One must also remember that full-time graduate work in our universities today is generally planned and conducted for young people up to approximately 26 years of age," the report says. "This is especially true in regard to master's degree work in administration."

To those people in the hospital field who have expressed the opinion that too many hospital administration stu-

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dents are being turned out, a chapter on the need for additional university programs will be of particular interest. Careful studies by the commission indicate that a total of 602 opportunities per year for graduates is available. These may be divided as follows: opportunities as chief administrator, 334; opportunities as assistant administrator and department heads, 232; opportunities in peripheral fields, 36. "It must be kept in mind that these are estimates of opportunities not of demand," the commission says. "The actual number of program graduates who will be sought and placed will be substantially smaller, although it is expected that over the years progressively more and more of the key positions in hospitals and peripheral areas will be occupied by program graduates. The chief determinant of demand for program graduates will be their success in relation to the success of persons entering hospital administration positions without the special education and development planned for the university program students. To some degree the disposition of the average board of trustees to pay its hospital administrator the most modest salary possible will favor the nongraduate over the graduate." It is pointed out, however, that this will be true less frequently as performance evidence accumulates in favor of students graduating from the hospital programs. "It is reasonable to believe that in the long run a large proportion of the vacancies for chief hospital administrators will be filled by graduates of the university programs." The commission feels that within a few years there should be a great enough demand for course graduates to warrant an increase to at least twice the present annual supply of graduates and says, "This could be achieved either by increasing the size of the student bodies in the present programs or by establishing additional programs." The report indicates that there is room for several new programs. "None of the existing programs necessarily should continue solely because it presently exists. With the passage of time, in all probability some of the universities which now conduct programs but which fail to appreciate fully the responsibilities involved and fail to provide adequate staffing and financing may not desire to continue. Unless sufficient adjustment is made, such programs should not survive."

CHANGES MUST BE MADE

A careful reading of the report makes crystal clear the commission's feeling that while the present directors and universities carrying out graduate education in hospital administration have filled an immediate need, attitudes, practices and policies must change radically if the courses are to produce people really skilled in administration in the environment of a hospital. It would seem that more and more hospital trustees are realizing the complexity of hospital administration and are interested, as they are in their own businesses and industries, in getting skilled leaders and executives. It is the belief of many that hospital trustees generally will applaud the commission's emphasis on proper foundational education in the technics of administration and the enlarging of this in the graduate programs. Widespread reading of the commission's report by hospital trustees will go far in the continuing education of trustees as to the complexity of hospital administration and the important characteristics, skills and abilities needed by hospital administrators.

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Hospital Unit for the Long-Term Patient

(*Continued From Page 68*)

3. The physically rehabilitative patients, *e.g.* those who require the facilities of the physical medicine and rehabilitation departments as a primary need with other professional services as supportive. Patients in this class are the amputees, some hemiplegics, and the paraplegics.

There are two possibilities for patients such as these—general hospitals and chronic disease hospitals, which are, in fact, general hospitals designed especially for service to long-term patients. Either may provide surgery, physical medicine departments, diagnostic and evaluation services, and complete facilities for long-term definitive management. Difference of opinion prevails as to the rôle of both types of hospital in long-term care. The question, therefore, is when and under what circumstances each of the two types of hospital can and should supply hospital care required by long-term patients. In some communities, chronic disease hospitals have been established to provide this care.

In some other situations, general hospitals have wards, wings or buildings set aside for long-term patients. Institutions catering to "well" aged persons or children sometimes provide facilities for this type of hospital care where it is needed and not otherwise available. Whether it is a separate hospital or a few beds allocated for the purpose, the unit to provide hospital care for the long-term patient must encompass the following, either actually within the unit or readily available:

1. Intensive evaluation and definitive medical treatment. If the unit does not, for example, possess the resources for intensive evaluation, there should be a workable and working arrangement with a facility which does have these resources.

2. A rehabilitation service organized so that rehabilitation is started immediately on admission. Special equipment will be required as well as specially trained staff imbued with a sound concept and philosophy of rehabilitation.

3. Physical surroundings planned and designed for persons who must live there for a prolonged period. This includes not only comfortable bedrooms and recreational rooms, but an atmosphere and regimen which recognize that the period of care will be prolonged and the level less intensive than that of the acute general hospital.

4. A schedule of charges which recognizes that long-term patients, except in extremely rare instances, cannot be expected to finance any program of care for an indefinite period, except at the most modest level possible. Most hospitals serving this group of patients will require a substantial subsidy, either public or private.

5. An effective discharge program. To be truly effective this means that the institution must make sure there exist proper places for patients to go when they no longer need the special services of the hospital. To accomplish this the chronic disease unit will probably need an affiliation with

nursing homes and other convalescent facilities and with programs providing care in the patients' homes. The unit will also need the services of a staff that will use this discharge program effectively, so as to avoid the blocking of hospital beds by patients requiring only domiciliary services.

6. A staff representing all of the various skills required for long-term care and with an understanding of the differences in the needs of the long-term patient and a genuine interest and appreciation of the importance and significance of this kind of care.

These are the features which characterize the chronic disease unit in hospital care. They are the fundamentals which must be present. To each planning group or hospital administrator they present a different challenge. The practical administrative problems which are posed depend in large measure on the physical facility. For example, if the chronic disease unit is a separate hospital the provision of resources for intensive evaluation will require that a staff arrangement be built up. If the unit is a part of a general hospital, the staff of the general hospital is a ready-made resource. On the other hand, proponents of the separate chronic disease facility will argue that the staff of the general hospital cannot be assumed to be the best solution as, unless carefully oriented, its interest in the long-term patient is subordinate to its interests in the more dramatic demands of acute illness.

As the Commission on Chronic Illness pursues its study of the problem the staff comes again and again to the question of the best method for hospital care of the long-term patient. The crux of this question is the place of the chronic disease unit.

The study group pondering the appropriate rôle of the chronic disease hospital for the National Conference on Care of the Long-Term Patient made the following observations which aptly summarize the questions posed for planners of hospital care for the long-term patient:

"It must be pointed out that if other agencies in the community performed all services for the chronically ill in an exemplary manner, there might be no need for a separate chronic disease hospital. Indeed, there are good reasons to believe that the intensive evaluation and definitive medical treatment of the long-term patient, the primary function of the chronic disease hospital, could best be done in the acute general hospital. It is perfectly clear, however, that that is not the case today, since in most general hospitals the tempo is designed for the acute case, and the atmosphere is such that the long-term patient is treated as a stepchild, or worse. The study group believes that much might be accomplished in some communities by establishing chronic disease units in general hospitals, provided these hospitals were willing to dedicate a suitable portion of their resources to the long-term patients, and concentrate in such units an adequate number of interested and well trained personnel.

"The important concept is that a variety of services is needed; all the links must be present and strong if the chain is to do its work. Under some circumstances, a community may find it desirable to have all links in one geographical location and under one administration. In most situations this will not be feasible, and proper functioning of the multiple services for long-term patients will depend upon effective cooperation among the several agencies dedicated to this task."

(*Continued From Page 86*)

no insurance company insuring a charitable institution may claim immunity from suit as grounds for refusal to defend a claim against the hospital.

Let us assume an accident in which an elevator falls, severely injuring a patient, with the result that he sues for damages. We believe that this claim would come within the scope of the general liability policy, and because of the Maryland statute the insurance company would be estopped from pleading immunity in the defense of the claim. However, let us further assume that, as has been his practice, the administrator fails to notify the insurance company of the accident and does not notify it when the suit for damages is filed, depending on the immunity of the hospital as a charitable institution to relieve the hospital of all liability for the injury. Although the statute is not clear, there is a good possibility that the court will hold that the hospital has waived its right to claim immunity by the purchase of general liability insurance. It will probably then be too late to ask the insurance company to undertake the defense of the claim and to pay any sum which the hospital may become obligated to pay; because if the company wants to, it can deny liability on the grounds that the assured failed to comply with the agreement in the insurance policy that it would give written notice of an accident to the insurance company as soon as practical and that it will immediately forward to the company every demand, notice, summons or other process received by him or his representative. Thus, through his misunderstanding of the insurance policy, the administrator has probably denied the hospital the right of defense and indemnity from the insurance company.

The situation described in this example will not apply exactly to the laws of many states, but it does serve to illustrate the need for a clear understanding of the insurance protection provided.

CONCLUSIONS

We believe that certain conclusions can be drawn from the foregoing discussion:

1. The comprehensive general liability policy, while broad in its scope, does not provide full liability protection to the hospital.

2. Hospital professional liability insurance is necessary fully to protect the hospital against liability for injury to patients from causes which are excluded from the comprehensive general liability policy.

3. Because of the many types of borderline injuries which may occur, the two types of liability insurance should be purchased from the same insurance company.

4. Regardless of whether or not the general liability and hospital professional liability insurance is purchased from the same company, the exclusions of one policy should be carefully compared with the coverage provided by the other to ensure that no unintended gaps exist.

BUDGETS are wonderful things when they are working properly—but, when it becomes necessary to reduce them, they can be hotter than the time-worn frying pan—and—in many such cases the Hospital Buyer is forced to jump into the fire of "cheap" merchandise. Such a move naturally never solves the problem—in fact, it usually proves to be more costly and adds to the budget instead of helping to reduce it. The one sure way to side-step this particular headache is, strangely enough, to purchase the finest products available. Take Surgical Gloves for instance . . . to buy the best you naturally have to pay a higher initial price—but—the very things that have made them the best, made them cost more, such as superior knowledge, superior workmanship, superior materials is the guarantee you have of a longer-lasting glove in actual service—and the longer a glove can "stay on the job" the lower the unit cost goes. Wiltex and Wilco Curved Finger Latex Gloves are noted for their longer-lasting qualities—for their lower unit cost over an extended period. So ask your Surgical Supply Dealer for them by name and avoid that "frying pan to the fire" jump. Ask for . . .

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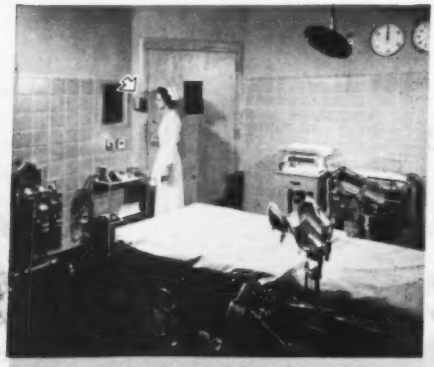
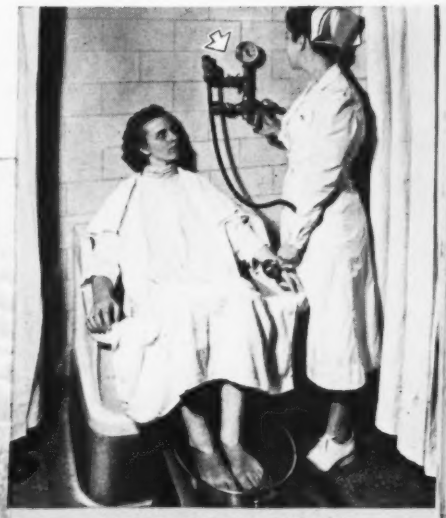
Deep Therapy X-Ray Room



Air-Conditioned Delivery Room

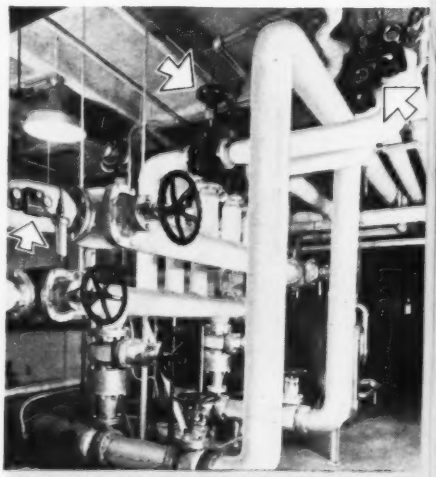


Powers Control on Sitz Bath with Raised Base

Treatment Bath for Children. Note Powers Mixer

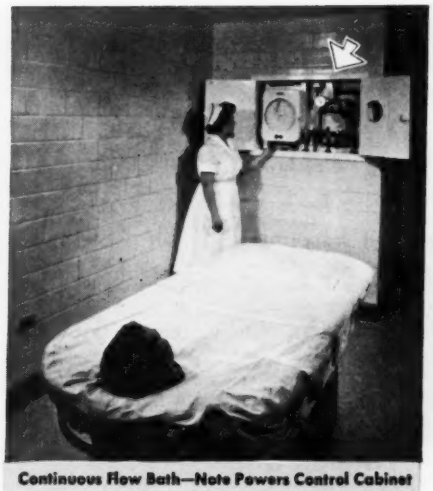
Section of Nursery

Powers Controlled Whirlpool Bath for Polio Patients

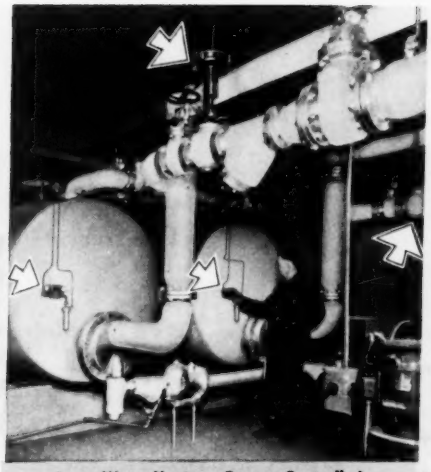


Controls on Forced Hot Water Heating System

Powers Thermostatically Regulated Showers



Continuous Flow Bath—Note Powers Control Cabinet



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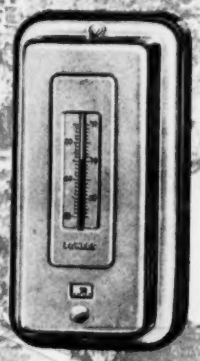

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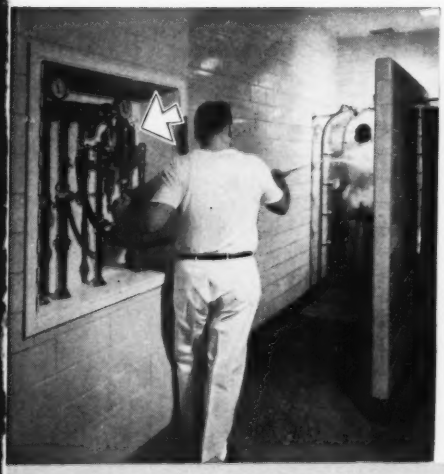
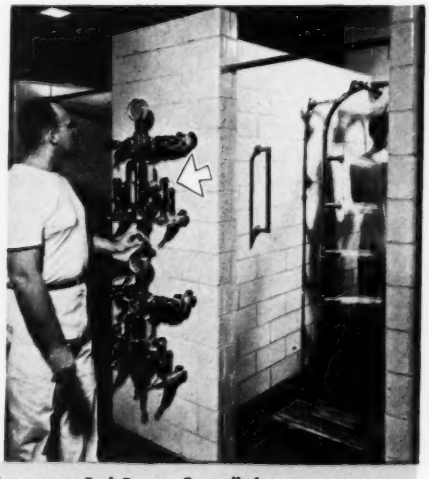




Scotch Douche and Hydrotherapeutic Showers are Both Powers Controlled

One of Three Iron Lungs in Children's Room

Steam Rooms Regulated by Powers Thermostats

NEWS DIGEST

Yale Law Students Urge Open Hospitals . . . A.H.A. Anticipates Record Crowd at Convention . . . Hawley Resigns From Welfare Group . . . Legion Attacks A.M.A. . . . Iowa Hospitals Fight Ruling . . . Massachusetts Wins Public Relations Award

Open Hospitals Urged by Yale Law Students in Report on A.M.A. Power

NEW HAVEN, CONN.—Hospital staff membership for every licensed physician was named as a desirable goal in an 84 page article on the American Medical Association appearing in the *Yale Law Journal,* published here last month. The article is based on a two-year study of the A.M.A. by David R. Hyde and Payson Wolff, who conducted the study as Yale law students and were graduated last June.

Hospital privileges for every physician were named in the article as a method of "deemphasizing" the importance of medical society membership, which the authors concluded resulted in "unreasonable exercise of organized medicine's authority."

By deemphasizing the importance of society membership, it was asserted, "the severe consequences of the medical society's disciplinary powers" would be mitigated.

"Perhaps the most effective method of deemphasizing membership would be to ensure availability of hospital privileges to nonmembers," the authors stated. Pointing out that one state, Montana, has legislation prohibiting discrimination by hospitals against any licensed physician, they continued, "This type of provision might require qualification in teaching hospitals and in urban areas where variations in the desirability of hospitals would necessitate some limitation on use of facilities. However, its primary effect is to remove organized medicine's coercive power over doctors without impairing professional standards."

The authors' analysis of A.M.A. "power, purpose and politics" was critical throughout. "The power of organized medicine affects not only the physician but also everyone who requires the assistance of the healing arts," they stated. "A.M.A. successes in raising the quality of medical education, practice and care are beyond question. However, in these endeavors it has acquired such power over both public and practitioner that it can channel the development of American medicine. Dangers inherent in such power are compounded by the layman's ignorance of medical matters and the A.M.A.'s monopoly position as spokesman for the profession.

"Out of this situation arise questions of grave significance. The A.M.A. is motivated both by obligations to the public and loyalties to its own members. The demands on it from these two points of view underlie all its activities and suggest possibility of conflict. To what extent does professional self-restraint, combined with present laws and institutions, assure that this conflict will be resolved in favor of the public interest?"

Commenting on the article, Dr. George F. Lull, secretary and general manager of the A.M.A., said it contained "basic and glaring errors of fact and omissions of vital facts." In many important sections, the text is based on completely false and erroneous information, Dr. Lull said. "It took the students two years to make the study, but they took neither the time nor the trouble to interview A.M.A. officers or staff people at Chicago headquarters to get their facts correct."

Among other things, Dr. Lull denied the authors' charge that the A.M.A. exerts undue authority over the individual physician. "The American Medical Association has almost no authority

(*Continued on Page* 160)

Record Crowd Expected at A.H.A. Convention; Program Features Outside Speakers, Panels

CHICAGO.—Total registration of hospital administrators, trustees, auxiliary members and employes, industry representatives and guests at the 56th annual convention of the American Hospital Association here September 13 to 16 is expected to reach a record 15,000, A.H.A. officials said as preparations were being completed to handle the oversize crowds at exhibition and meeting halls on Navy Pier.

The last time the A.H.A. met in Chicago was in 1907, when Asa S. Bacon, long-time superintendent of Chicago's Presbyterian Hospital, was first named treasurer of the association —an office he occupied for 35 years.

Scheduled meetings of the association's house of delegates will be held Sunday morning preceding the convention and again on Tuesday and Wednesday mornings.

In addition to general sessions on public needs, public opinion and hospital accreditation, the program will feature panel discussions on administrator-trustee-staff relations, hospital planning, purchasing, methods improvement and financial management.

As it has for the last several years, the program will also include a Wednesday evening session devoted to discussion of association services.

Convention speakers from outside the hospital field will include Dilman Smith of the Opinion Research Corporation, Princeton, N.J.; Sen. Lister Hill of Alabama; Dr. Alan Gregg, vice president of the Rockefeller Foundation; Milton Silverman, science editor of the *San Francisco Chronicle;* Benson Ford of the Ford Motor Company, Detroit, and Edward L. Ryerson of Chicago, chairman of the Inland Steel Company.

General theme for the 56th convention is "Improvement of the Care of the Patient," which is also the keynote for the annual conference of the association's committee on auxiliaries.

NEWS...

Open Hospitals Urged by Yale Law Students

(*Continued From Page* 158)

over individual physicians," he asserted. "It is the county medical society that disciplines members who are guilty of unethical practices."

Replying to the suggestion that opening hospital staff privileges to all licensed physicians would "deemphasize" the importance of medical society membership, Dr. Lull said: "The American Medical Association has no control whatsoever over hospital staff appointments, which are made by local hospital boards of trustees." Dr. Lull also termed "false and malicious" the authors' allegation that the A.M.A. controls the nation's supply of doctors through exercise of its authority over medical schools. "The A.M.A. has no control over the nation's supply of doctors," he said. "The Yale Medical School admissions committee and all similiar committees throughout the United States determine the number to be admitted. The A.M.A. has nothing to do with control over the supply of doctors."

The students' project was based on studies of the A.M.A.'s published records, interviews with both critics and supporters of A.M.A. policy, and questionnaires directed to state medical societies. The report dealt with A.M.A. structure and operations, and with its activities in connection with medical education, methods of practice, prepayment and insurance, government medical services, and other subjects having public or political interest or importance.

In a section dealing with methods of remunerating the physician, the authors studied the controversy between hospitals and various specialty groups. "Medical societies have characterized hospital practice as primarily a moral problem," they stated. "They fear exploitation and lowering the dignity of the profession, and envision lay-employer control as forcing a lower standard of care for the patient."

Relating the appointment and conclusions of the Hess Committee, the authors report that "there has been neither extensive nor highly successful activity on the lower levels. . . . While state specialty societies have impeded the spread of salaried practice to new hospitals by refusing to recommend, or threatening to expel, a member who accepts salaried terms, they have not effected any appreciable change where the practice is already entrenched.

"The national organization is unable to initiate action in cases of individual violations of the Hess Report, since it is bound by its constitution to wait for charges to proceed through regular channels. Instead, its officers have tried to work out agreements that can deter salary-paying hospitals. They have requested Blue Cross to refuse to pay hospital bills covering charges for salaried doctors' services. Conferences have been held with American Hospital Association officials in an effort to work out a compromise arrangement. Both sides have denied an irreconcilable conflict, but after four years of negotiation there is still no agreement."

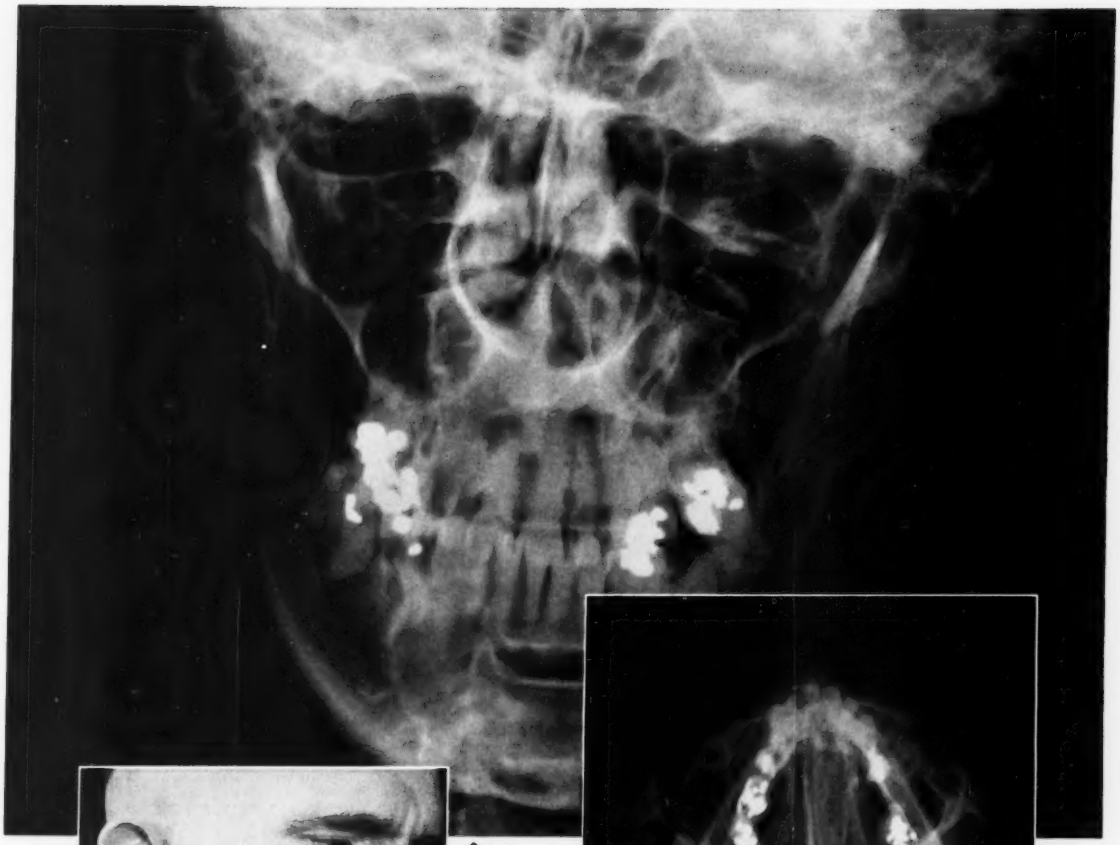
Elsewhere, the authors detail methods used by A.M.A. and other doctors' groups in combating legislation thought to be inimical to the interests of physicians, at one point describing the "A.M.A. lobby" as "the most powerful in the country." In a footnote, the authors report a *New York Times* story in which one observer is quoted as saying, "Some rather expert observers of the art of lobbying as practiced in Washington assert that the A.M.A. is the only organization in the country that could marshal 140 votes in Congress between sundown Friday night and noon on Monday."

In a concluding statement of rebuttal, Dr. Lull said: "The real danger in this article is that nearly all the facts are given a negative slant, whereas they just as well could have been presented in a positive light. It is very apparent that the authors built up a straw man and then proceeded to knock him down. It is an obvious attempt to neutralize the conservative influence of one of America's great voluntary health organizations."

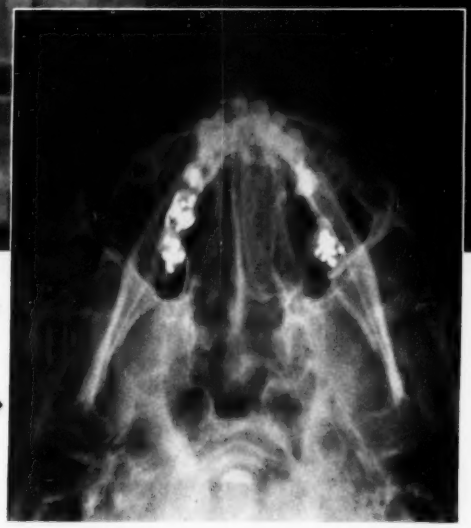
Patients Escape Fire at Moline Mental Hospital

MOLINE, ILL.—More than 100 patients at East Moline State Hospital here were led to safety when a two-story brick building on the hospital grounds was destroyed by fire.

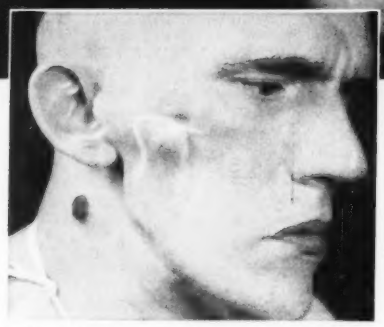
An employe in the hospital recreation department was overcome by smoke while escorting 64 women patients and 43 men patients from the burning building, it was reported.



Preoperative posteroanterior radiograph.



Preoperative superoinferior radiograph.



Photograph of patient prior to radical surgery.

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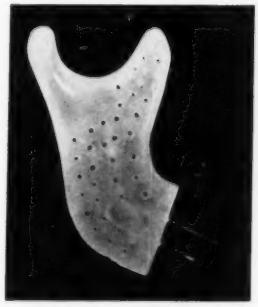
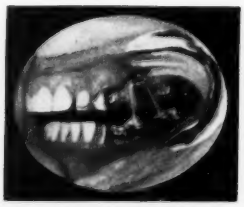
Radiographs and photographs: Veterans Administration Hospital, Bronx, New York.



Acrylic prosthesis.



Onlay-type guide plane to maintain articulation and to prevent drift of mandible.

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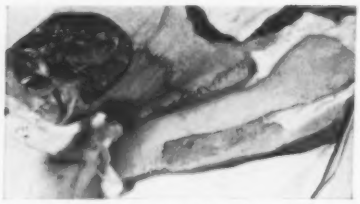
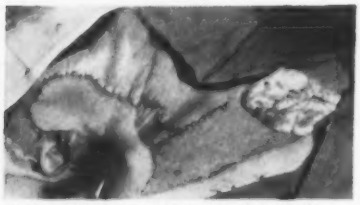
ONE-STAGE EXCISIONAL AND RECONSTRUCTIVE SURGERY.

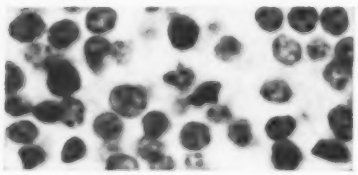
Radical neck dissection completed.



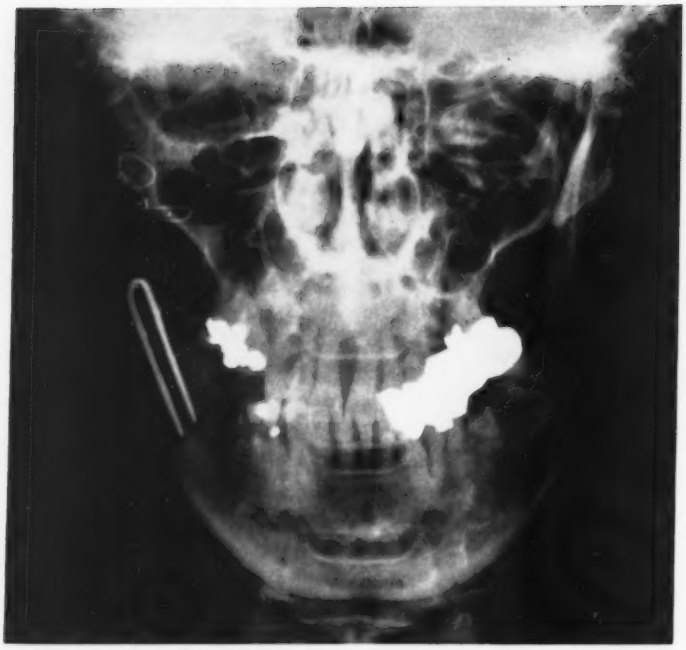
Total parotidectomy, resection of mandible, spinofacial anastomosis, immediate mandibular reconstruction.



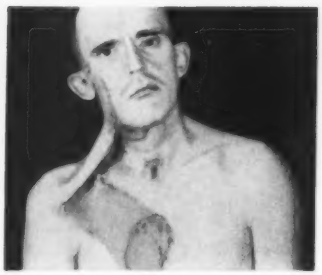
Closure of defect with tubed pedicle graft.



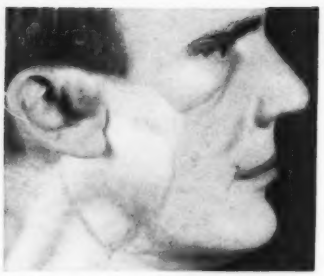
Photomicrograph (×1000) of resected tissue.



Postoperative posteroanterior radiograph.



Photograph of patient 3 weeks after operation.



Photograph of patient 22 months after operation and after detachment of tube.

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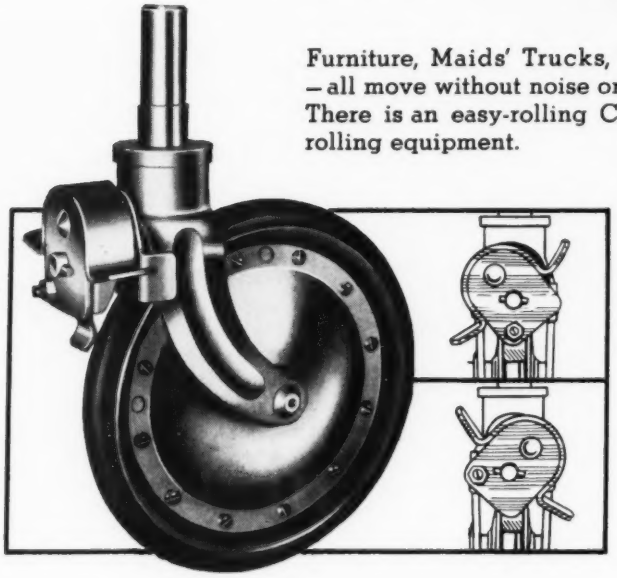

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NEWS...

Blue Cross-Blue Shield Honor Massachusetts for Public Relations Program

CHICAGO.—Massachusetts Blue Cross and Blue Shield won the grand award for the best public relations program for plans with enrollment of 500,000 or more, the Blue Cross-Blue Shield commissions announced here at the annual public relations and enrollment conference last month.

Blue Cross plans at Concord, N.H., and Phoenix, Ariz., won top honors for the best public relations programs among the smaller groups, it was announced.

More than 200 public relations and enrollment representatives of Blue Cross and Blue Shield plans attended the three-day conference, which featured seminar sessions dealing with problems of management, advertising, hospital and physician relations, labor, government and other subjects of interest in Blue Cross and Blue Shield operations.

In addition to Blue Cross and Blue Shield executives, and hospital and medical authorities, lecturers and group leaders at the conference included public relations and sales representatives of industry.

In addition to the general award winners, other Blue Cross and Blue Shield plans were named as winners of class awards, in subscriber relations, community relations, institutional promotion, enrollment promotion, hospital and physician cooperation, and annual reports. The winners were: Hospital Service, Inc., of Iowa and Iowa Medical Service (Des Moines) for subscriber relations; Hospital Care Association, Inc., (Durham, N.C.) for community relations; Group Hospital Service, Inc., and Surgical Medical Care, Inc., (Kansas City, Mo.) for institutional promotion; Associated Hospital Service of New York and United Medical Service, Inc., (New York) for both enrollment promotion and hospital and physician cooperation, and Hospital Service of California (Oakland) for annual reports.

The judges also awarded 16 other plans honorable mention certificates for outstanding achievement in their public relations programs.

Approximately 250 delegates from Blue Cross and Blue Shield plans in the United States and Canada attended the conference.

Judges in the public relations com-

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2. **Universally Interchangeable**—The micro-precision grinding of SEMPRA'S makes universal interchangeability possible.
3. **Continued Interchangeability**—7 years field experience proves, given reasonable care, long service improves the ice-hard, silk slick finish so that after years of service they still interchange and still meet Federal specifications.
4. **Parallel Sides**—Only ground glass surfaces can be absolutely parallel, assuring you freedom from constriction.
5. **Longer Life**—SEMPRA'S ground glass surfaces are free of scratches, therefore alkalis frequently present in sterilizing media get no foothold to cause dangerous pits.
6. **Accurate Dosage**—Because they conform to only one set of tolerance specifications, they're uniform in volume.

Yes, you get all these advantages plus many other extras when you specify SEMPRA'S, the original interchangeable syringe. Try some to-day and see how much you save tomorrow.

J. BISHOP & CO. PLATINUM WORKS MEDICAL PRODUCTS DIVISION • MALVERN, PA.

petition were: Phelps Johnston, account executive of Campbell-Mithun Inc.; Joan Wilcox, assistant public relations director of the Encyclopaedia Britannica, and Warren Thompson, public relations director of the Chicago Title and Trust Company.

Nassau Hospitals Dispute Report on Quality of Care

MINEOLA, N.Y. — A dispute over the quality of care rendered in Nassau County hospitals flaired here last month following release of a survey conducted by Dr. John Gorrell for a Citizens Committee for Health and Hospitals in Nassau County.

A. Holly Patterson, Nassau County executive, said the survey finding that medical care in hospitals in the county was "poorly controlled" was not justified by the facts. On the contrary, he said, the county's tuberculosis sanitarium and Meadowbrook Hospital were "rated among the highest in standards in the nation." The county's rapidly growing population created hospital pressures which accounted for any difficulties revealed in the survey, Mr. Patterson stated.

Released last month, the Gorrell report indicated that medical staffs at the county hospitals failed to supervise hospital medical practice closely enough.

The survey was sponsored by the Citizens Committee for Health and Hospitals in Nassau and recommended that a hospital council be established to coordinate hospital planning and fund raising and work with county authorities to adopt legislation on hospital policies and practices.

The report noted that members of the house staffs at four voluntary hospitals in the area were inadequately trained and criticized "questionable accounting practices" in some of the hospitals.

It also included recommendations to curtail hospital expansion in parts of the county and expand elsewhere, to meet the needs of growing populations.

In his reply, Mr. Patterson pointed to a survey finding indicating that 90 per cent of hospital patients interviewed said they would return to the same hospital again. "This would seem to be convincing proof of how Nassau County people feel about their hospitals," he stated.

Dr. Hawley Opposes Plan for Mental Hospital; Resigns From Welfare Group

CHICAGO.—Dr. Paul R. Hawley, director of the American College of Surgeons, has resigned as chairman of the Board of Public Welfare Commissioners, an advisory group to the governor and state welfare director, it was announced here last month.

Dr. Hawley resigned in protest over plans to build a $5 million hospital for research in mental diseases, it became known. The research hospital was recommended by the Pyschiatric Research Council, an advisory group consisting of psychiatrists on the staffs of Chicago hospitals and medical schools. Dr. Percival Bailey, University of Illinois psychiatrist, headed the group recommending the research institution.

Dr. Hawley's position was that state funds should be spent for improving patient care in existing state hospitals, not for a research building, according

NEWS...

to his letter of resignation addressed to Gov. William Stratton. "While appreciating the importance of research, I believe the immediate problem in Illinois is not one of gaining more research knowledge but the inability to apply what is already known," the Hawley letter stated. "It's buying diamonds for kids in rags," he asserted.

Dr. Hawley pointed to the shortage of psychiatrists in existing hospitals as evidence that an additional research hospital could not be adequately staffed, even if it were built. He suggested state funds could be used to pay higher salaries to attract better men to the present hospital system.

Plans for the project call for a special fund to be collected from the families of patients able to pay for their own care in state hospitals. The fund is expected to total $9 million by June 1955. The proposed hospital would be built on the site of the West Side Medical Center in Chicago.

Dispute Between Staff and Administrator Ends; Trustees Fire Them All

PITTSBURGH.—John J. Haluska, administrator of the 146 bed Miners' Hospital at Spangler, Pa., and all 16 members of the medical staff were discharged by the hospital's board of trustees last month following a dispute over the administrator's proposal to establish a quack "cancer clinic" at the hospital.

Following Haluska's announced intention of importing Texas cancer quack, Harry Hoxsey, who sells a "cancer cure" made of alfalfa and hay, the 16 doctors on the staff of Miners' Hospital had resigned. At first supporting the administrator, hospital trustees filed suit for an injunction to restrain the doctors from resigning or from treating their patients at any other hospital.

Then the U.S. District Court at Dallas, Tex., issued an injunction restraining Hoxsey from shipping his cancer cure in interstate commerce, and preventing distribution of circulars describing his nostrums. In an effort to bring an end to the dispute, hospital trustees, by a close vote, moved against Haluska, who is a member of the state legislature, and, in a surprise action, then dismissed all the staff members as well as 15 dentists and technicians who had supported the doctors.

INDIANA UNIVERSITY MEDICAL CENTER
Student Union and Food Service Building

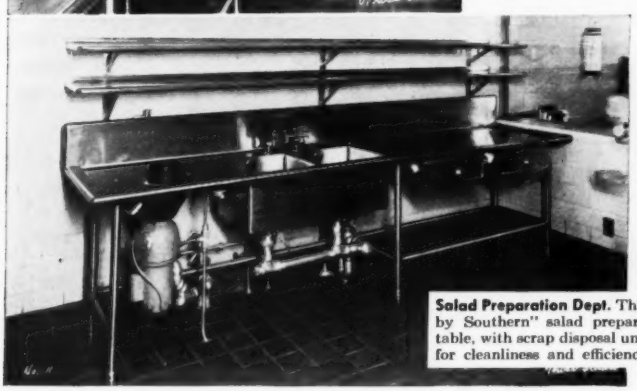
Eggers and Higgins, *Architects* Edw. D. James, *Architect*

Entire food operation—including this completely equipped banquet kitchen on the mezzanine—accommodates a maximum of 917 persons at one time.

Dishwashing Dept. Mechanically washed and rinsed dishes remain in racks and pass over a forced heated air drier to expedite drying.

SOUTHERN DEALER PLANS and INSTALLS PRIZE-WINNING KITCHEN

Starting with a detailed analysis of the contemplated menu and the purchasing procedure, National China & Equipment Corporation, Marion, Indiana, achieved a precise allocation of space for storage, preparation and service at the Student Union & Food Service Building in Indianapolis. Three separate operations—cafeteria, snack bar and banquet service—are served from a central kitchen. This modern, efficient installation won a First Award in the 1954 Institutions Food Service Contest.



Salad Preparation Dept. This "Custom-Bilt by Southern" salad preparation sink and table, with scrap disposal unit, was designed for cleanliness and efficiency.

Get expert help with your next kitchen equipment problem or layout—call your "Custom-Bilt by Southern" dealer or write Southern Equipment Company, 5017 So. 38th Street, St. Louis 16, Mo.

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COMING EVENTS

AMERICAN ASSOCIATION OF BLOOD BANKS, Shoreham Hotel, Washington, D.C., Sept. 13-15

AMERICAN ASSOCIATION OF HOSPITAL ACCOUNTANTS, Accounting Conference, Springfield, Ill., Oct. 13, 14.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Sheraton-Cadillac Hotel, Detroit, Oct. 4-8.

AMERICAN ASSOCIATION OF NURSING HOMES, Annual Convention, Seelbach Hotel, Louisville, Ky., Oct. 18-20.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Annual Meeting, Palmer House, Chicago, Sept. 11-13. ***Institutes for Hospital Administrators:*** 22d Chicago Institute, University of Chicago, Aug. 31-Sept. 10; 5th Chicago Advanced Institute, University of Chicago, Sept. 6-10; 9th Southern Institute, Richmond, Va., Nov. 1-5.

AMERICAN DIETETIC ASSOCIATION, Commercial Museum and Benjamin Franklin Hotel, Philadelphia, Oct. 26-29.

AMERICAN HOSPITAL ASSOCIATION, Navy Pier, Chicago, Sept. 13-16.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Shoreham Hotel, Washington, D.C., Oct. 16-22.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Annual Meeting, Hotel Baker, Dallas, Tex., Oct. 21-Nov. 3.

ARIZONA HOSPITAL ASSOCIATION, Hotel Westward Ho, Phoenix, Nov. 15-17.

CALIFORNIA HOSPITAL ASSOCIATION, Hotel Californian, Fresno, Oct. 28, 29.

COLORADO HOSPITAL ASSOCIATION, Annual Convention, Cosmopolitan Hotel, Denver, Oct. 26-27.

CONNECTICUT HOSPITAL ASSOCIATION, Southern New England Telephone Company Auditorium, New Haven, Nov. 10.

FLORIDA HOSPITAL ASSOCIATION, Annual Meeting, Colonnades Hotel, Palm Beach Shores, Nov. 17-19.

ILLINOIS HOSPITAL ASSOCIATION, Hotel Abraham Lincoln, Springfield, Dec. 2, 3.

KANSAS HOSPITAL ASSOCIATION, Baker Hotel, Hutchinson, Nov. 11, 12.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Annual Conference, Hotel Shoreham, Washington, D.C., Nov. 15, 16.

MISSISSIPPI HOSPITAL ASSOCIATION, 23d Annual Convention, Hotel Heidelberg, Jackson, Oct. 13-15.

MISSOURI HOSPITAL ASSOCIATION, Hotel Jefferson, St. Louis, Dec. 2, 3.

NEBRASKA HOSPITAL ASSOCIATION, Hotel Fontenelle, Omaha, Oct. 14, 15.

ONTARIO HOSPITAL ASSOCIATION, Annual Convention, Royal York Hotel, Toronto, Ont., Oct. 25-27.

WASHINGTON STATE HOSPITAL ASSOCIATION, Chinook Hotel, Yakima, Sept. 29, 30.

1955

ALABAMA HOSPITAL ASSOCIATION, Annual Meeting, Tutwiler Hotel, Birmingham, Jan. 13, 14.

CANADIAN HOSPITAL ASSOCIATION, Biennial Meeting, Chateau Laurier Hotel, Ottawa, Ont., May 9-11.

MASSACHUSETTS HOSPITAL ASSOCIATION, Annual Meeting, Hotel Statler, Boston, May 25.

NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Annual Convention, Palmer House, Chicago, Feb. 9, 10.

OHIO HOSPITAL ASSOCIATION, Netherland Plaza Hotel, Cincinnati, March 7-10.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta Biltmore Hotel, Atlanta, Ga. April 20-22.

WISCONSIN STATE HOSPITAL ASSOCIATION, Milwaukee, March 17.

Save time and steps for nurses with CRANE

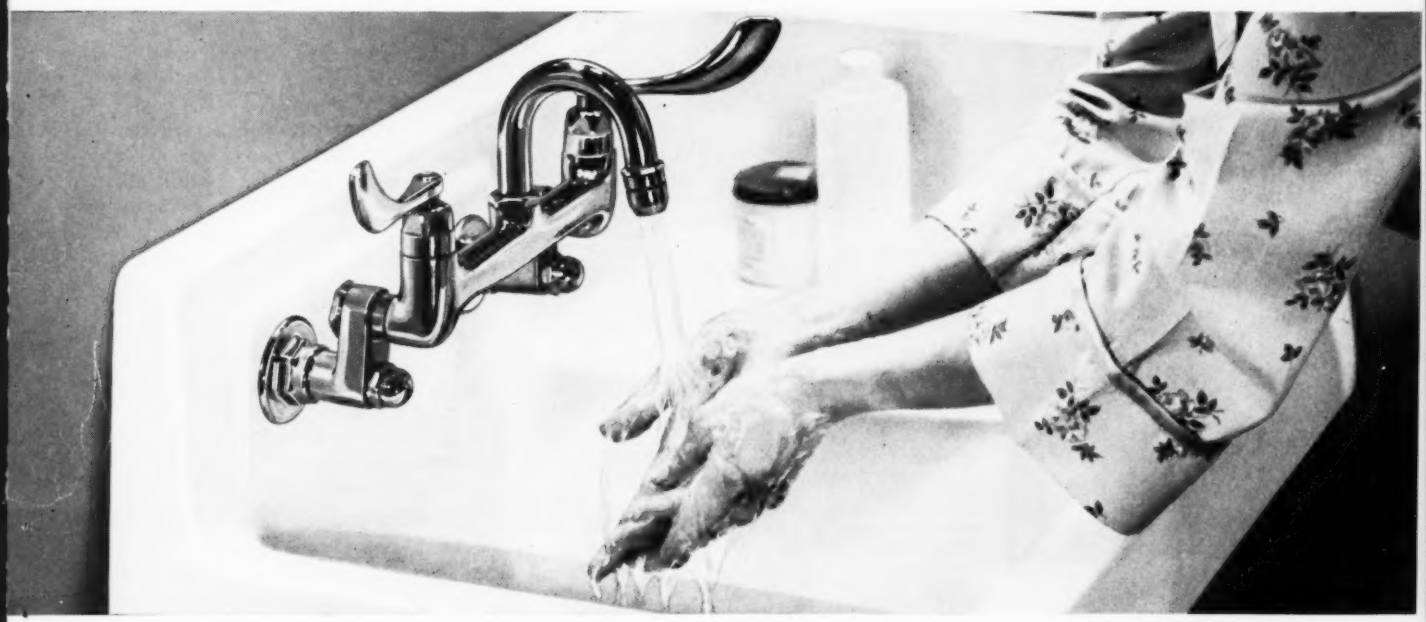
In hospital after hospital, the nursepower shortage has been relieved by the effective use of Crane specialized plumbing fixtures. That's because the right fixtures, properly placed, help ease the nursing shortage by . . .

Crane Hygiene lavatory can be placed in either corner of the patient's room or bathroom, or along the wall.

(1) *Removing much lost motion, hundreds of needless steps, and many unnecessary tasks from a nurse's day.*

(2) *Aiding in making the profession of nursing more attractive by making the work easier, faster, more pleasant.*

Developed with the help of hospital experts to meet specific hospital needs, Crane fixtures conform to the best in good hospital practice and sound hospital management.



New Crane fixture encourages patients to care for themselves

Specially designed for installation in patients' rooms and wards, Crane's new Hygiene Lavatory is equipped with wrist-action Dial-ese controls. And it has an integral shelf for water pitcher, toilet articles, and other patient needs.

By being conveniently near and easy to use, it is a standing invitation to convalescent patients to care for themselves instead of ringing for a nurse.

The Hygiene is the only lavatory especially made for patients' use, and is a good example of the way Crane meets specific hospital needs with specialized design.

For complete information about this and other Crane specialized hospital equipment, see your Crane Branch, Crane Wholesaler or Plumbing Contractor.

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NEWS...

Legion Attacks A.M.A. Position on V.A. Care of Nonservice Disabilities

CHICAGO. — The American Medical Association and others seeking to curb free hospitalization and medical care of nonservice-connected disabilities in Veterans Administration hospitals were bitterly attacked by Arthur J. Connell, national commander of the American Legion, in an address to the Illinois chapter of the legion at its annual convention here last month.

Mr. Connell charged the A.M.A. and other critics of the V.A. hospital program were "against any hospitalization for veterans." He hinted that Congress should investigate "dollar conscious doctors."

Replying for the A.M.A., Dr. George F. Lull, secretary, restates the association's position that V.A. should pay doctor and hospital bills, and for treatment of tuberculosis and mental illness. For care of nonservice-connected disabilities, the association holds, the veteran should seek treatment at his own expense. Yet the fact is, Dr. Lull said, that 85 per cent of patients admitted to veterans hospitals are seeking care for some condition having no relation to military service.

Commenting on the dispute, an editorial in the *Chicago Tribune* pointed out that restriction of free medical care to service-connected disabilities "seems quite a bit removed from being 'against any hospitalization for veterans,' as Mr. Connell charges. Nor is it altogether true that the legion is not, in his phrase 'asking handouts or free rides for 20 million veterans.'

"Mr. Connell spoke of 20 million veterans. They are only the beginning. The Eisenhower Administration is seeking permanent peace-time conscription under which every moderately able-bodied boy will be taken when he is 18½, or through college, and automatically made a veteran of our armed forces. Nearly half of the adult males today are veterans. In another generation the only pure quill civilian males will be those with flat feet, conscientious objections or the intelligence quotients of morons.

"If present V.A. policies are continued, and veterans continue to get free hospitalization for civilian ills, we shall have socialized medicine for the simple reason that few men will be left who are obligated to pay their own doctor bills.

"The American Legion is one of the country's strongest bulwarks against the forces that want to make the state master of the citizen. It should realize that in seeking free hospital beds for its members it is bartering away their freedom."

Philanthropic Gifts Rise in 1954 Over 1953

NEW YORK. — Philanthropic gifts and bequests in the first six months of 1954 increased substantially over the same period in 1953, according to a study made by the John Price Jones Company, Inc.

Covering published records of benefactions over $1000 in New York, Baltimore, Boston, Chicago, Houston, Los Angeles, Philadelphia, Pittsburgh, St. Louis and Washington, D.C., the Jones study reported total gifts in the 10 cities at $374,960,710 in the first six months of 1954, compared with $247,979,097 for the same six months of 1953.

Mid-State Baptist Hospital, Nashville, Tennessee

QUIET: Ingredient for Recovery

An important and recognized treatment-aid for the hospital patient is the recuperative help of *rest and quiet*. Yet many of America's fine hospitals do not abide by this basic prescription, and the jarring, recovery-retarding but routine noises of daily hospital chores often remain unchecked.

Low-Cost Noise-Abater

The healing benefits of a comfortably *quiet* atmosphere are today being realized, however, in hundreds of hospitals . . . through Acousti-Celotex Sound Conditioning. In wards, nurseries, operating and delivery rooms, corridors, lobbies, kitchen, utility rooms . . . sound-absorbing ceilings of economical Acousti-Celotex Tile curtail irritating, disturbing noises. Convalescence is aided considerably by this restful quiet, while the working efficiency of hospital personnel is also improved.

Maintained with Ease

Quickly, easily installed, Acousti-Celotex Tile requires no special maintenance, and no continuing expense thereby. Provides excellent sound-absorption value plus a surface of unusual beauty that can be washed *repeatedly* and painted *repeatedly* with no loss of sound-absorbing efficiency.

Mail coupon today for a Sound Conditioning Survey Chart that will bring you a *free analysis* of your particular noise problem plus a free factual booklet, "The Quiet Hospital." No obligation.

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Without cost or obligation, please send me the Acousti-Celotex Sound Conditioning Survey Chart, and your booklet, "The Quiet Hospital."

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NEWS...

Iowa Hospitals and Doctors Disagree on "Practice of Medicine" Ruling

DES MOINES, IOWA.—State hospital and medical associations here were in sharp disagreement last month about a recent ruling by Attorney General Leo Hoegh that hospitals employing doctors on salary or percentage arrangements are engaged in illegal practice of medicine.

In a special meeting, state hospital association officers decided to resist the ruling by asking for additional, clarifying opinions based on facts of hospital operation, and, if necessary, seeking court action or changes in the medical practice act.

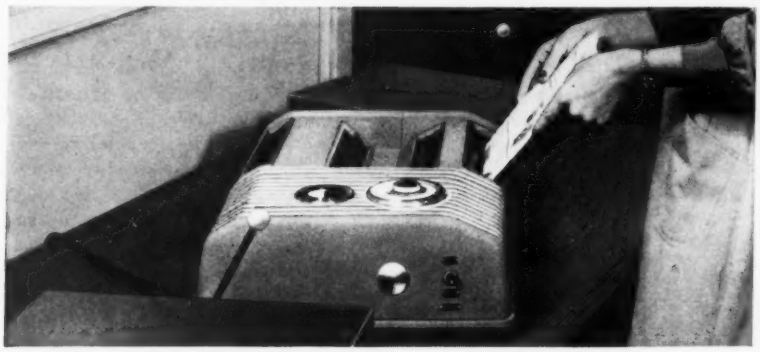
Efforts of the Iowa Hospital Association to prevent radiologists and pathologists at hospitals throughout the state from switching to a private fee basis of practice were supported by an editorial on the subject in the *Des Moines Register.*

"The *Register* believes that a strained interpretation of the law is being used in an effort to force Iowa hospitals to abandon their present method of employing medical specialists," the editorial stated. "Most hospital radiologists [who give x-ray treatments] and pathologists [who examine tissues] now are under contract to hospitals. The hospital recruits these specialists, furnishes the equipment they use and employs the technicians who work under the specialists. It collects a fee from the patient for the specialist's services, and pays him either a flat salary or a percentage of income from fees for that department.

"The Iowa Hospital Association, Inc., opposes any substantial change in this method of employing radiologists and pathologists. The Iowa Medical Society is backing the specialists in their demand for a change.

"The specialists think they should not be 'employes' of the hospital in any sense. They want to lease, rent or buy the equipment from the hospitals, to have full charge of employment of technicians and to bill patients directly for their fees. They don't want to be anonymous.

"The specialists obtained, through the state board of medical examiners, an 'opinion' from the attorney general's office which they are using in an attempt to get the hospitals to abandon the present method of employment. This opinion, given in February, was



IMMEDIATE RECORD COPIES PRODUCED BY ONE SIMPLE AND INEXPENSIVE MACHINE

Here's big news for busy hospital personnel. Sharp, clear, positive photocopies of your vital records can now be made in *seconds* with the Remington Rand Transcopy Duplex.

You don't need a darkroom, messy liquids or spread-out array of equipment—this one compact unit does the whole job. It exposes, develops and prints any record or chart, whether typewritten, hand written, printed or drawn—up to 14 inches wide and of any length.

And there's no problem of installation. You just plug into any standard electrical outlet and you're all set to make immediate copies of data for patients' record files, doctors and other hospitals . . . and copies of patients' bills for insurance companies or welfare departments.

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Modern "fireproof" hospital construction is not enough to safeguard your vital records against fire. Nor can you rely on a fire-resistive safe to protect them. About half of all fires at institutions start during the daytime—when records are in use. You could not ask your staff to risk their lives by carrying records to a safe, if a fire started.

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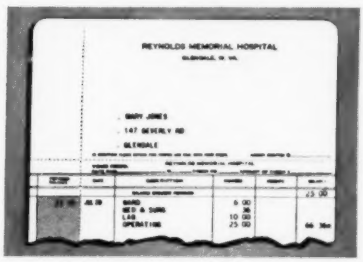
or exceed the stated ratings. And just as important is the fact that this equipment is designed for maximum work-saving efficiency.

If your narcotics records, active patient's records, accounts receivable and other important records are not now protected at point-of-use—consider for a moment the possible consequences of a flash fire. You can get expert help from your local Remington Rand representative—or send for our free booklet **SC684.**

Accounting Ills Cured by Mechanization

Delays at check-out time, hand posted statements with high error potential, no current accounting data—all add up to a sick record-keeping operation.

If your bookkeeping suffers from any of these symptoms, it's due for a thorough check-up by an accounting methods specialist. Your Remington Rand representative is just such a man. He can show you how other hospitals have mechanized



their patient accounting, accounts payable, inventory accounting and payroll—with amazing results. You'll see how simultaneous posting of a charge or credit to all related records saves time and money—avoids transcription errors, too. How machine accuracy gives you proved up-to-date balances and totals. And how you get a complete picture of your receipts and expenditures, broken down the way you want it, *as an automatic by-product of normal posting.*

As a start, why not send for the story of Remington Rand mechanized accounting methods at the Reynolds Memorial Hospital? It's told in the words of Mr. George O. Smith, Office Manager. Just circle **SN758.** Also, ask for **AB593,** which illustrates another way of mechanizing hospital patient accounts.

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Yes, I'd like the literature circled.

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H-7

that (1) corporations operating hospitals are violating Iowa law through 'practicing medicine' when they hire pathologists and radiologists under the present plan; and (2) physicians who enter into contracts with hospitals providing for payment by salary or on a percentage basis are guilty of unprofessional conduct because they are engaging in illegal 'fee splitting.'

"Hospital administrators and trustees point out correctly that this is an 'opinion,' not a court ruling. They disagree as to its legal soundness, and they believe it would not be in the best interests of the public. Perhaps it will be necessary to bring a court suit to determine the question, although certainly every effort should be made to settle the disagreement without legal action.

"It won't make sense to most people to say that a hospital is illegally practicing medicine because it employs a pathologist or x-ray specialist. Nor will the public regard giving a percentage of the fee to the specialist as objectionable fee splitting. And it takes quite an imagination to see the danger of socialized medicine in present hospital practices.

"But the public's main concern—and that of hospitals and the medical profession, too—is with the effect any change might have on the care of and costs to patients. We believe the hospital association is right in its contention that the change wouldn't benefit patients.

"The change might not immediately result in higher costs, but we think that would be the tendency when specialists billed the patients directly. It's highly unlikely that specialists would lower charges or take a smaller percentage of the fees than they now receive. If the hospitals get less money, that just confronts them—and this means the public since hospitals are nonprofit organizations—with another financial problem.

"The change would not result in patients getting any better care. It might create problems. Would specialists be as willing to buy special equipment if they had to pay for it as are the hospitals? Would it be more difficult to obtain services of specialists at hours needed if they were not under hospital control? And who would assume the responsibility—if the present plan were abandoned—of seeing that specialists are available at hospitals where they are needed?

"It seems to us that the medical profession would be wise to work out a program for going along with hospitals in their present method of employing specialists."

Iowa Hospital Association officials have determined to fight the attorney general's ruling and, if necessary, take the problem to the state legislature, the *Register* reported on August 12.

Administrators and trustees, meeting with association attorneys, were reported in favor of the following action:

"1. If possible, getting the attorney general to withdraw his original opinion.

"2. If the opinion would be withdrawn, obtaining an additional opinion 'based on a full and correct statement of facts.'

"3. If the additional opinion still is adverse, get a declaratory judgment (court decision).

"4. If court action fails, or in lieu of court action, work for a change in

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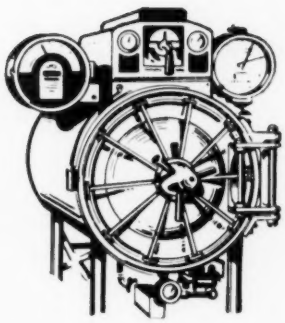
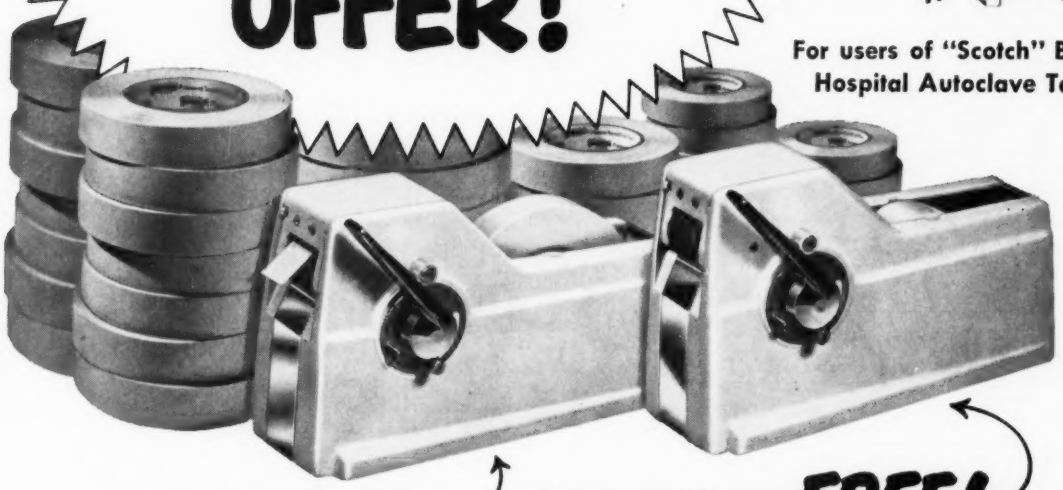


For users of "Scotch" Brand Hospital Autoclave Tape



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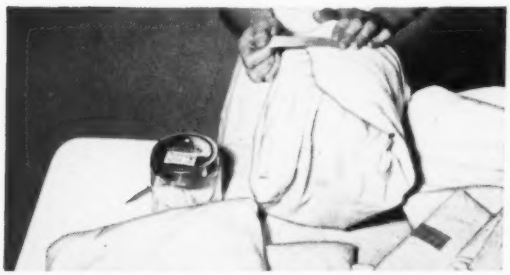
One bulk carton of "Scotch" Hospital Autoclave Tape No. 216 (48 ¾-inch rolls or 36 one-inch rolls) together with one of these new white hospital-model "Scotch" Definite-Length Tape Dispensers. Another brand new, gleaming white hospital-model Definite-Length Dispenser will be given you at no extra cost! These new dispensers operate by lever action—dispense pre-measured lengths of tape to cut your tape costs as much as ⅓! A limited offer—expires November 30!



SAVE HALF THE TIME ordinarily needed to prepare packs for autoclaving! "Scotch" Hospital Autoclave Tape eliminates pinning, string tying, tucking. It both seals and identifies . . . holds firmly in high steam temperatures, can be written on with pencil or ink, leaves no stains or gummy residue.

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OFFER "AB" (For users of ¾-inch tape)
One bulk carton of ¾-inch Autoclave Tape (48 60-yard rolls) and a pair of white hospital-model Definite-Length Dispensers are yours for only $61.07. You save $15.95 over the regular price!

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One bulk carton of Autoclave Tape (36 60-yard rolls) in one-inch width, plus two white Definite-Length Dispensers cost you only $59.15. It's your opportunity to equip every floor with these tape-saving dispensers!

Act quickly—offer limited!

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SCOTCH BRAND HOSPITAL AUTOCLAVE TAPE NO. 216

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The term "Scotch" and the plaid design are registered trademarks for the more than 300 pressure-sensitive adhesive tapes made in U.S.A. by Minnesota Mining and Mfg. Co., St. Paul 6, Minn.—also makers of "Scotch" Magnetic Tape, "Underseal" Rubberized Coating, "Scotchlite" Reflective Sheeting, "Safety-Walk" Non-slip Surfacing, "3M" Abrasives, "3M" Adhesives. General Export: 122 E. 42nd St., New York 17, N.Y. In Canada: London, Ont., Can.

the Iowa medical practice act in the 1955 legislature."

In a meeting with Attorney General Hoegh on August 17, the hospital association submitted its statement of additional information on which it asked him to withdraw his opinion that hospitals are violating the medical practice act under some of their existing procedures.

At this meeting, the attorney general stated he will modify his ban against hospitals' "hiring x-ray and laboratory doctors" if the opposing groups can agree on a new "statement of facts." If he does make a new or supplemental opinion, the attorney general stated, it will be his final one.

In its statement, the hospital association cited three types of hospitals which make use of the services of pathologists in different ways, and requested the attorney general to make a specific ruling in each group as to whether the hospitals or the physician-pathologists are in violation of the medical practice act, it was explained.

Representatives of the medical society have reserved the right to pass on the additional information submitted by the hospital group after careful study. Earlier, the medical society had accepted a "compromise plan" suggested by the attorney general, but this compromise was rejected by the hospitals.

Union University Reveals Reorganization Plan for School of Nursing

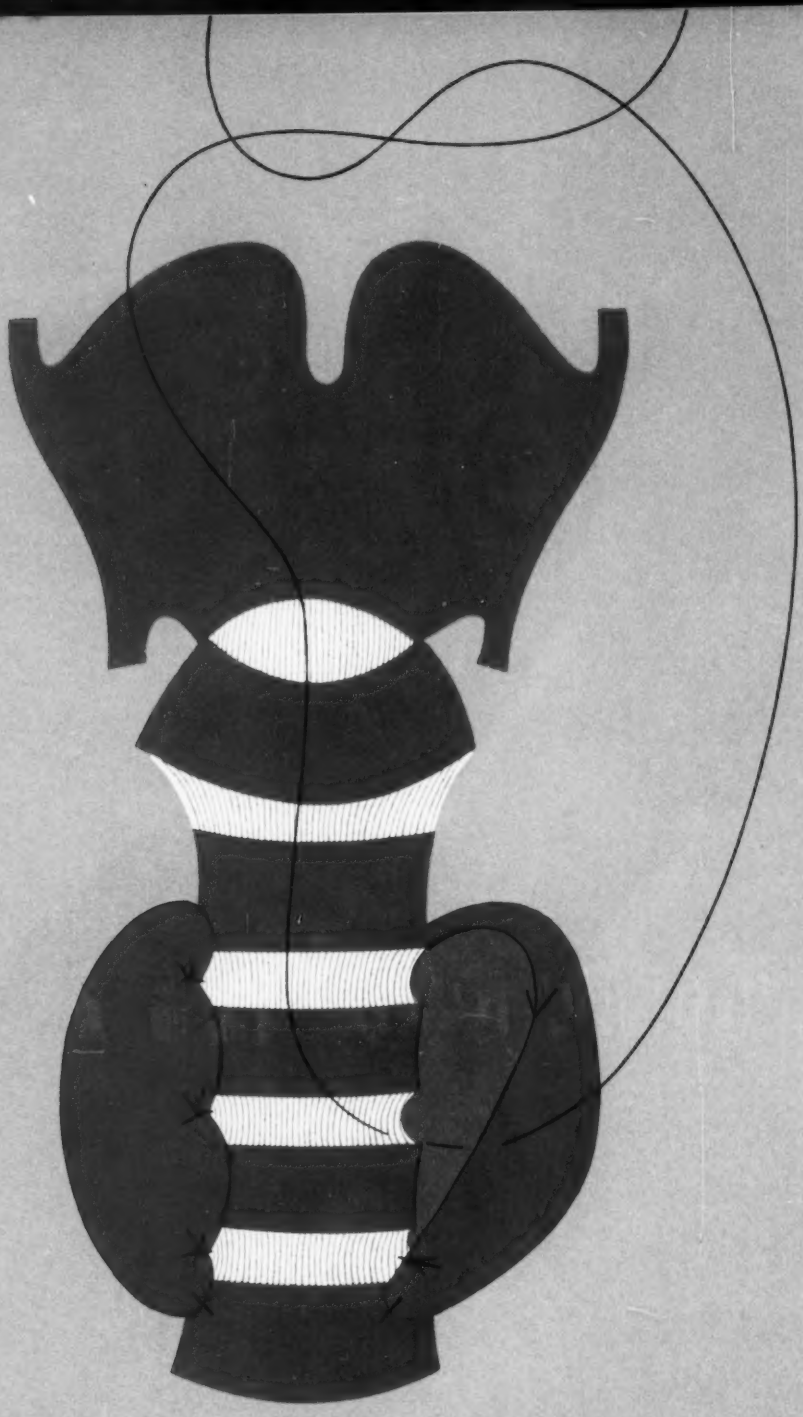
ALBANY, N.Y.—Marion S. Wood, acting director of the Union University School of Nursing, on August 13 revealed the institution of a series of moves to reduce the financial burden to students entering the nursing school at Albany Medical Center here. Effective for the new class enrolling for September 1954, the first of the moves is a tuition cut which will total $300 for the three years. The new tuition schedule will begin after the preclinical period, it was stated.

Second in the fight against rising student costs in an effort to win over the nursing shortage, officials revealed, is the establishment of senior internships which will pay student nurses a monthly stipend during the last six months of their schooling.

"Senior internships are something entirely new in the state of New York," explained Miss Wood. "Made possible by condensing classwork into two and one-half years and the reduction of formal lecture requirements, the period of internship provides greater opportunity for students to put into practice the nursing skills they have been learning. Supervision and ward teaching will continue through these last six months.

"The $180 which now will go to senior interns in the nursing school should come as a great help to the many students who have limited financial resources. To others it will be an opportunity to learn the wise use of money in preparation for their work experience following graduation.

"Practice during the internship," Miss Wood continued, "will be directed toward more skilled and advanced nursing technics and responsibilities. By this method, the student will be better prepared for her increased responsibilities as a team mem-



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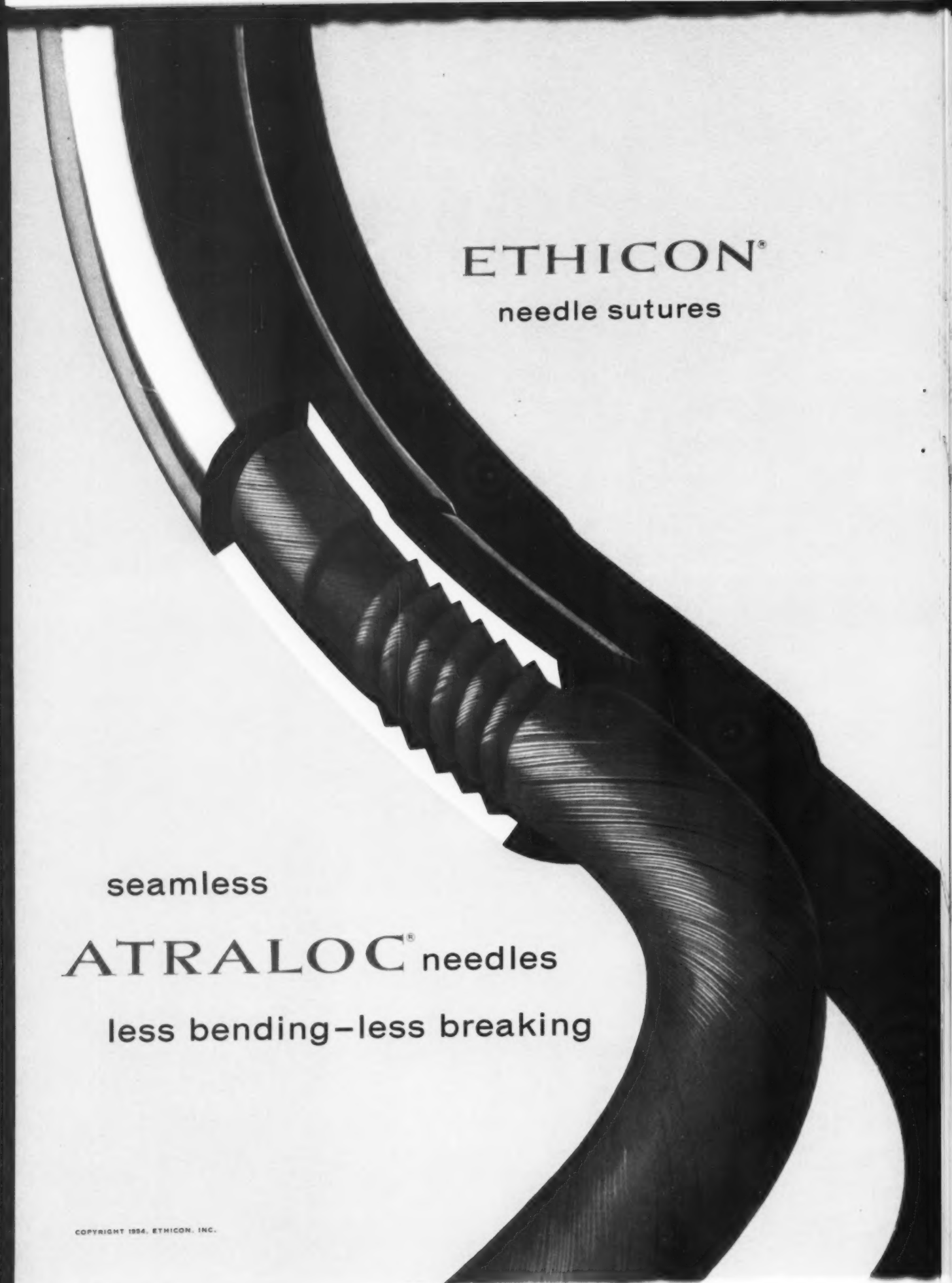

ber and a team leader, and finally for her rôle as a graduate nurse."

A further feature of the revised program aimed at saving the student nurse costs in her training period is the shortening of the preclinical period from eight months to six months. By reduction of the period in which students pay for their own meals, there will be a saving in food costs of approximately $100.

Dr. Thomas Hale Jr., director of the Albany Medical Center Hospital and associate dean of the Albany Medical College, of which the Union University School of Nursing is a part, simultaneously announced a contributing plan to the nursing school's new financial program which will also help to alleviate the financial burden of nursing education.

"Since the new program for the school of nursing calls for a March as well as a September class," stated Dr. Hale, "many candidates for the March class will have to seek employment prior to the beginning of their formal education at the nursing school.

"Where better can a candidate for the school of nursing work during this interim period than in the medical center where she will receive her professional education? Albany Hospital, in its desire to cooperate fully with the school of nursing and in its effort to contribute to the worthy cause of encouraging young women to enter the nursing profession, proposes to offer candidates for admission to the March class a period of prenursing school training in the hospital, during which period they will be paid for their services like any other employe.

"At the election of the candidate, monies earned in the prenursing school training program may be accumulated by the hospital and turned over to the school of nursing to pay tuition and other costs of the student when she begins her formal education there. Under this plan, it will be possible for a school of nursing candidate to bank the sum of $1000 from the time of her graduation from secondary school in June to the time she begins her educational program in the nursing school the following March. This sum of money will more than cover the total costs of the student's three-year nursing school education.

"Work assigned to the prenursing school candidate will vary from laboratory assignments to assisting nurses in their duties. Not only will the candidate become familiar with hospital technics and practices, but she will gain knowledge which should prove helpful to her in nursing school," Dr. Hale concluded.

Roosevelt Hospital to Build New Nursing School

NEW YORK.—A contract for approximately $1,000,000 to construct a new four-story Roosevelt Hospital School of Nursing building here was awarded last month, Garrard Winston, hospital president, has announced.

The steel frame building will provide approximately 26,650 square feet of floor space, including a basement which will be used for recreational facilities. Laboratories, conference and lecture rooms, administrative offices, and dormitory facilities will be located on the other floors of the building. York and Sawyer are the architects.

"A campaign, started in October 1952 and conducted by the hospital's volunteer committee," Mr. Winston

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NEWS...

said, "provided the funds for the new building which will be located between 58th and 59th streets near 10th Avenue. Under the leadership of Mrs. Donald F. Bush, chairman of the nursing committee of the board of trustees, and Mrs. J. Joseph Mylott, who was then chairman of the volunteer committee, a total of $820,261 was raised and an additional $100,000 pledged.

"The generosity of friends of the hospital, the efforts of the volunteer committee and the active support of the members of the board, as well as the medical and nursing staffs, were responsible for the success of the campaign," Mr. Winston added.

Pennsylvania Hospital Receives $335,000 Grant

PHILADELPHIA.—Pennsylvania Hospital here has received a grant of $335,000 from the Hartford Foundation, Inc., of New York. The foundation was established by the late John A. Hartford, who was president of the Great Atlantic and Pacific Tea Company.

The grant will be used in part to modernize the hospital's oldest building, Pine Street Hospital Building, which provides care for medically indigent patients. A series of institutes and lectures for practitioners in Philadelphia and the surrounding states has been planned. The new program will allow the hospital to function as a liaison agency between the medical practitioner and latest scientific developments, hospital officials explained.

Iowa Elects New Officers

DES MOINES, IOWA. — Herbert M. Krauss, former administrator of Burlington Hospital, Burlington, Iowa, has resigned as president of the Iowa Hospital Association. At a recent meeting new officers were elected. Louis B. Blair, St. Luke's Hospital, Cedar Rapids, is now president. Other new officers are: first vice president, Anne L. Lachner, Hospital Service, Inc., Des Moines, and second vice president, Dorothea Ely, Jennie Edmundson Hospital, Council Bluffs. Former officers who are still serving are: president-elect, Nellie M. McLaren, Delaware County Memorial Hospital, Manchester, and treasurer, Lois M. Sherman, Sartori Memorial Hospital, Cedar Rapids.

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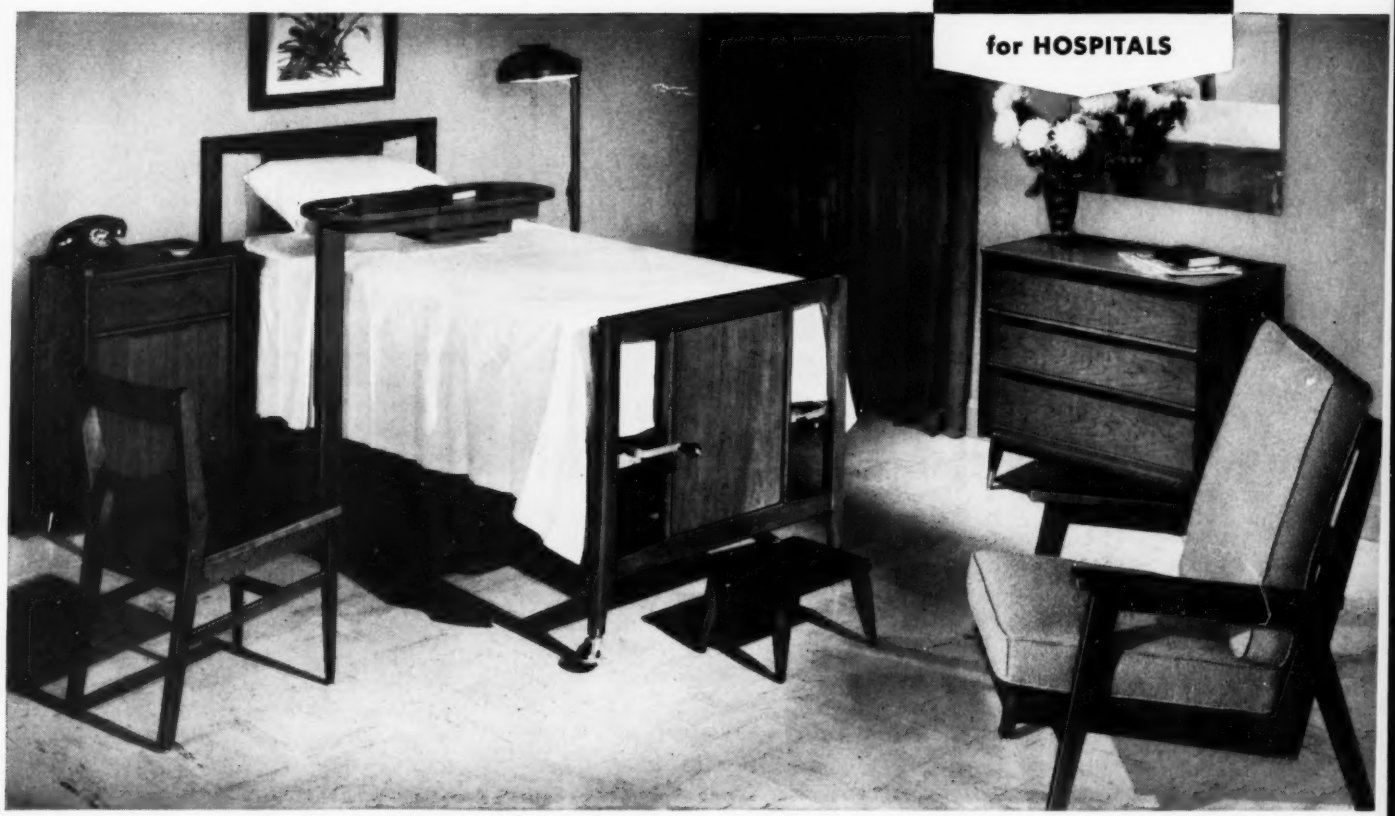

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NEWS...

Pathologists Interpret Canons of Ethical Code

CHICAGO.—The College of American Pathologists, through its board of governors, has issued an interpretation of certain canons in its code of ethics. The interpretations of Canons V, VI, VII and VIII follows:

Canon V.—I shall not issue reports to patients except when requested to do so by the patient's attending physician.

"Common professional courtesy demands that the pathologist, as a consultant to whom work is referred by a clinician, report his findings back to the referring physician. The attending physician is best able to correlate the pathologist's or his laboratory's findings with the entire clinical picture and to tell the patient or patient's relatives what they should know. A failure to observe this courtesy as a rule is certain to lead to situations that are embarrasing to the pathologist and are not in the best interests of the patient.

"There are occasions when the pathologist is in the best position to report and interpret to the patient. Such action should always be with the knowledge and consent of the referring clinician, or at his request."

PROFESSIONAL STANDING

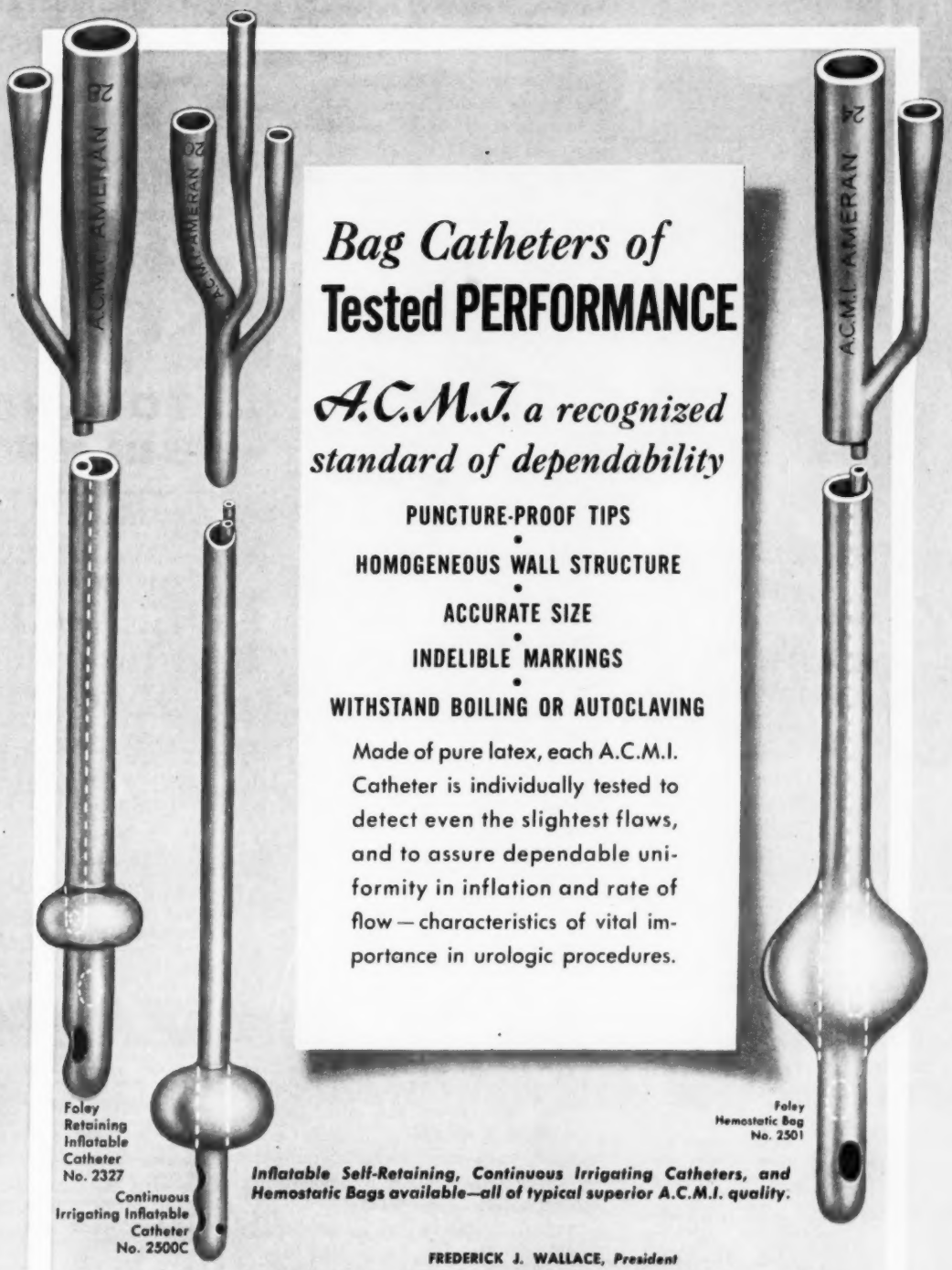
Canon VI.—I shall not participate, directly or by means of any subterfuge, in any arrangement whereby an individual, not regularly licensed to practice medicine, is encouraged to operate a clinical or pathological laboratory.

"The practice of pathology is recognized as the practice of medicine; laboratory tests carry therapeutic or diagnostic implications. Functioning as a part, albeit often technical, of the practice of medicine, it is our belief that clinical laboratories should be directed by pathologists who are regularly licensed physicians, and it is our conviction that such an arrangement serves the best interests of the patient. Any laboratory to which a pathologist lends his name should be under his immediate supervision so that he can influence and be responsible for its professional standards, and it should be operated to the financial gain or loss of the pathologist alone.

"Many states do not require that clinical laboratories be directed by regularly licensed physicians. In such cases, laymen may desire the 'front' of a pathologist to maintain an air of respectability with the medical profession in the operation of a commercial laboratory. Such a position is usually offered with the temptation of easy financial gain to which a pathologist has no ethical right. In the long run, such capitalization on a pathologist's name gives him meager compensation for his loss of professional standing."

Canon VII.—I shall not accept a position with a fixed stipend in any hospital, clinic or sanitarium which is owned and operated for profit by an individual, partnership, or corporation; however, I may be affiliated with such an organization as a private physician practicing my specialty and receiving fees for service.

"This canon is a corollary to the statement of the American Medical Association concerning the purveyal of medical service (Chap. 3, Art. VI, Sec. 6, Principles of Medical Ethics, A.M.A.). Its words 'owned and operated' for profit define the sphere of its jurisdiction. In a profit institution or



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NEWS...

organization, the pathologist's service is usually sold at a fee to the recipient patients. Such situations usually lead to exploitation of the pathologist who is on a salary, permitting others to profit unduly from his efforts. It is the firm belief of the College that a pathologist should practice, and be compensated, on the same basis as any other physician. In all institutions or organizations operated for profit, the principle of fee-for-service should apply to all. This canon does not prevent the pathologist from associating with profit-making groups provided he is a participating shareholder in the proportion to which laboratory income participates in the over-all income. He also may give service to such an organization on a straight fee-for-service basis.

"In this canon, the word 'clinic' is taken to include all of its several definitions.

"Although this canon does not directly apply to tax-supported or nonprofit groups, where a fixed stipend may be accepted, that stipend should reflect in some measure the volume of work and the responsibilities involved. The definition of 'nonprofit' is subject to the complexities of legal, social and economic interpretation. There are many situations in which the commonsense meaning of the word has been lost in the ramifications of these definitions or interpretations. Such evolutions in terminology will require continual study and interpretation by the College.

REFER PROBLEMS TO COLLEGE

Canon VIII.—I shall not accept a position in any hospital or other medical organization which does not conform to such relationships between the institution and the pathologist as may be approved by this College.

"The canon infers and offers the good offices of the College in defining or ruling upon any question concerning relationships between pathologists and institutions. Any relationship considered questionable by a member should be referred to the College for approval. When possible, this reference should be made before and not after the relationship is accepted, to avoid future embarrassment. The canon requires that its members be aware of and observe the pronouncements of the College on institutional relationships."

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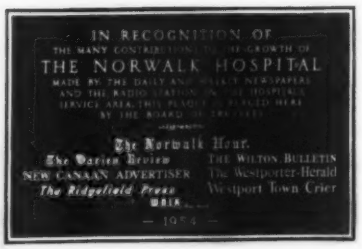
NEWS...

Plan 4000 Bed Hospital

ALBANY, N.Y. — A new 4000 bed state mental hospital is to be built in the Pelham Bay Area of the Bronx, New York, Gov. Thomas E. Dewey announced recently. Construction dates have not yet been announced but funds for the acquisition of land and start of building were appropriated in the 1952-53 and 1954-55 budgets. The 124 acre site is near the Bronx Municipal Medical Center and Albert Einstein College of Medicine.

Hospital Dedicates Plaque to Press

NORWALK, CONN. — The friendly and cordial relations that have existed between Norwalk Hospital and the press and radio station of Norwalk have been given recognition by the hospital with the unveiling of a commemorative plaque. It was presented at a "surprise dinner" by the president of the hospital's board of trustees. The plaque acknowledges the helpfulness of the press and radio station in reporting hospital events and programs and has been hung in the lobby of the hospital.



ABOUT PEOPLE

(*Continued From Page 90*)

served his residency under Dr. Branton and has been assistant administrator for several years. **Woodrow W. Fanning,** who has just completed his administrative residency at the hospital and has received his master's degree in hospital administration from Northwestern University, is now assistant administrator.

Margaret Ranck, formerly nurse consultant for nursing homes and homes for aged for the Illinois State Department of Health, Springfield, has opened an 18 bed nursing home in Carthage, Ill.

Claude Witten, purchasing agent for Plainview Hospital and Clinic Foundation, Plainview, Tex., is now administrator there.

Martin Saren, former administrative assistant at Grasslands Hospital, Valhalla, N.Y., has been named assistant director, administrative, there. Mr. Saren attended the graduate course in hospital administration at the University of Minnesota and served his administrative residency at Grasslands Hospital.

Forrest E. Brown, former manager of Northern Pacific Beneficial Association Hospital, Tacoma, Wash., has been appointed administrator of Forks Hospital, Forks, Wash., succeeding **Willis Parr,** who has been named administrator of Rowley General Hospital, Mount Vernon, Wash.

C. H. Denning, business manager at Hendrick Memorial Hospital, Abilene, Tex., has been named assistant administrator of the hospital. **Guy Hamilton,** who has been with the hospital since 1947, is now administrative assistant in charge of the business office.

Ray B. Goetze, formerly administra-

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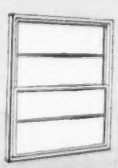

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tive resident at St. Louis City Hospital, St. Louis, has become administrative assistant at Highland View Hospital, Cleveland. Mr. Goetze did his academic work in hospital administration at St. Louis University.

O. C. Branham, formerly employed at Winter Veterans Administration Hospital, Topeka, Kan., has become administrative assistant of the Atchison, Topeka & Santa Fe Hospital in Topeka.

Paul H. Keiser, administrator of Community Hospital of Evanston, Evanston, Ill., has been named administrator of Burlington Hospital, Burlington, Iowa, succeeding **Herbert M. Krauss,** who has resigned. Mr. Keiser received his M.S. in hospital administration from Northwestern University.

Bentley Frederick, formerly administrator of Children's Hospital, Louisville, Ky., has become administrator of Little Traverse Hospital, Petoskey, Mich., succeeding the late **Leonard Schomberg.**

Malcolm D. MacCoun, assistant director of Malden Hospital, Malden, Mass., is now assistant administrator at Hackley Hospital, Muskegon, Mich.

Robert G. West, former administrative resident at California Hospital, Los Angeles, has been appointed assistant administrator of the new Methodist Hospital, Lubbock, Tex. Mr. West is a recent graduate of Northwestern University's course in hospital administration and holds a master's degree in business administration from the University of Michigan. He is a member of the American Hospital Association.

Dr. William F. Fellows, manager of the Veterans Administration Hospital, Albany, N.Y., is now manager of the new Veterans Administration Research Hospital, Chicago, succeeding **Dr. Thomas F. Barrett,** who has resigned to enter private practice.

Anthony E. Coletti, who has been staff physician in charge of the male section at Mendota State Hospital, Madison, Wis., has become clinical director of Central State Hospital, Lakeland, Ky. Dr. Coletti succeeds **Dr. Charles W. Morris,** who has resigned to enter private practice.

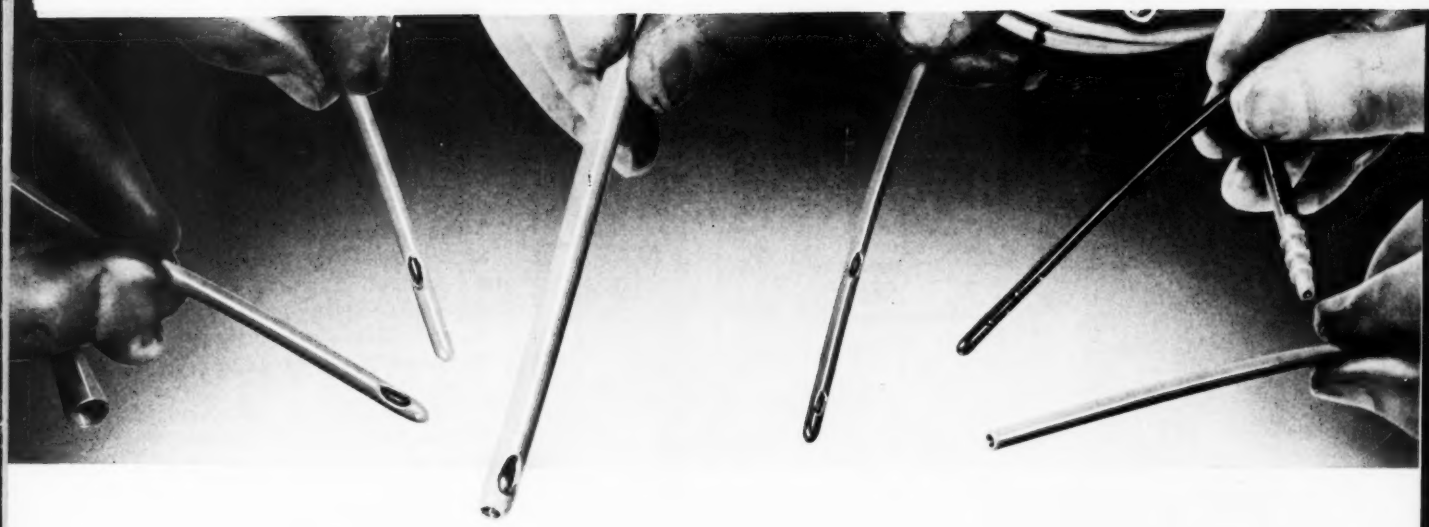
Milton H. Sisselman, administrative assistant at Mount Sinai Hospital, New York City, has been named assistant director of the hospital. Mr. Sisselman came to Mount Sinai in 1952 as resident in hospital administration. He is a member of the American Statistical Association, of the American Hospital Association, and of the American Public Health Association.

Charles T. Patterson has resigned as superintendent of Buena Vista County Hospital, Storm Lake, Iowa. He is immediate past president of the Iowa Association of Hospital Superintendents.

Paul J. Connor Jr., who was assistant director of Rockford Memorial Hospital, Rockford, Ill., is now associate director there. Mr. Connor was formerly assistant director of Middlesex General Hospital, New Brunswick, N.J. A graduate in hospital administration from Columbia University, he is a member of the Illinois Hospital Association and of the American Hospital Association.

Beatrice M. Bonnevie, who has been serving as administrator of the outpatient department in conjunction with her duties as social service director of New England Hospital, Boston, has been appointed assistant director of the hospital. Mrs. Bonnevie holds a master's degree in social service from Catholic University in Washington, D.C.

Gammon Jarrell, administrator of Southern Pacific Hospital, Houston, Tex., has become assistant director of Texas Children's Hospital and of St. Luke's Episcopal Hospital in Houston.



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Each	$ .45	$ .45	$ .55	$1.00	$ .50	$ .45
1 to 12 doz. per doz.	4.00	4.00	5.20	9.20	4.20	4.00
Over 12 doz. per doz.	3.60	4.60	4.68	8.28	3.78	3.60

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Horry Hair Jr. has been named business manager of Suwanee County Hospital, Live Oak, Fla., succeeding **Isabella Williams,** who has resigned.

John Rowland, who has been active in hospital and clinic work in Arkansas for a number of years, is now business manager of McAlester Clinic, McAlester, Okla., succeeding **Jack V. Sutherland,** who has resigned.

Dr. Charles E. Fiman, previously employed at DeWitt State Hospital, DeWitt, Calif., has been appointed clinical director of Larned State Hospital, Larned, Kan.

Hazel Mitchell, R.N., who has been doing private nursing in Spokane, Wash., has been appointed superintendent of Valley View Hospital, Colville, Wash., succeeding the late **Eileen Hutchison.**

Lavergne Guenther, who has been on the hospital staff of Tarpon Springs Hospital, Tarpon Springs, Fla., for the last three years, has been appointed acting superintendent there, succeeding **Mrs. N. T. McGurn,** who has resigned.

Robert E. Adams, who has been assistant administrator at Research Hospital, Kansas City, Mo., for the last five years, has been named administrator there. He had been acting administrator for the last 10 months.

William B. Sheldon, formerly administrator of Kingston Hospital, Kingston, N.Y., is the new administrator at Paul Kimball Hospital, Lakewood, N.J., succeeding **Marie Licht,** who has resigned. Miss Licht, who was formerly administrator of Bushwick Hospital, Brooklyn, N.Y., is a past president of the Hospital Council of Brooklyn.

Harold W. Maysent, who has completed his administrative residency at Passavant Hospital, Chicago, and has received his master's degree in hospital administration from Northwestern University, has been named administrative assistant at Passavant.

Horace Burgin, formerly administrator of Burge Hospital, Springfield, Mo., has accepted a position at Barnes Hospital, St. Louis, and at present is associate director of St. Louis Maternity Hospital, St. Louis.

Dr. William David May, who was director of the division of tuberculosis of Stanislaus County Hospital, Modesto, Calif., is now deputy superintendent at the tuberculosis sanatorium at Veterans Administration Hospital, Legion Branch, Kerrville, Tex. Dr. May is a graduate of the University of Tennessee School of Medicine.

Rubie M. Carlson, R.N., who has

been administrator of Allen Memorial Hospital, Waterloo, Iowa, for the last 15 years, has become administrator of Platteville Municipal Hospital, Platteville, Wis. A graduate of the school of nursing of the University of Minnesota, Miss Carlson is a fellow of the American College of Hospital Administrators and a member of the American Hospital Association and of the American Nurses' Association. She is a past president of the Iowa Hospital Association and has been associated with the hospital division of the Iowa Blue Cross.

Charles Leslie Gwinn, a recent graduate in hospital administration from the University of Virginia Medical College, has been appointed business manager of Pungo District Hospital, Belhaven, N.C. He succeeds **Mrs. E. C. Nicholson,** who has resigned.

CORRECTION

On page 178 of the August issue of The MODERN HOSPITAL, the appointment of **Dorothy Morgan,** formerly director of nursing and administrative assistant of the University of Chicago Clinics, as administrator of the Elizabeth Steel Magee Hospital, Pittsburgh, was reported erroneously. Miss Morgan has been appointed assistant administrator of the Elizabeth Steel Magee Hospital. Her appointment will become effective September 1.

John M. Shaw was erroneously reported last month to have been a graduate in hospital administration from St. Louis University and to have served his administrative residency at Barnes Hospital, St. Louis. Mr. Shaw is a graduate of Washington University, St. Louis, and served his administrative residency at Missouri Baptist Hospital in St. Louis.

Department Heads

Emma E. Heller, director of the school of nursing of The Jewish Hospital of Brooklyn, N.Y., since 1943, has resigned, effective September 1, it has been announced. At the same time,

Emma E. Heller

Beatrice Rudnick

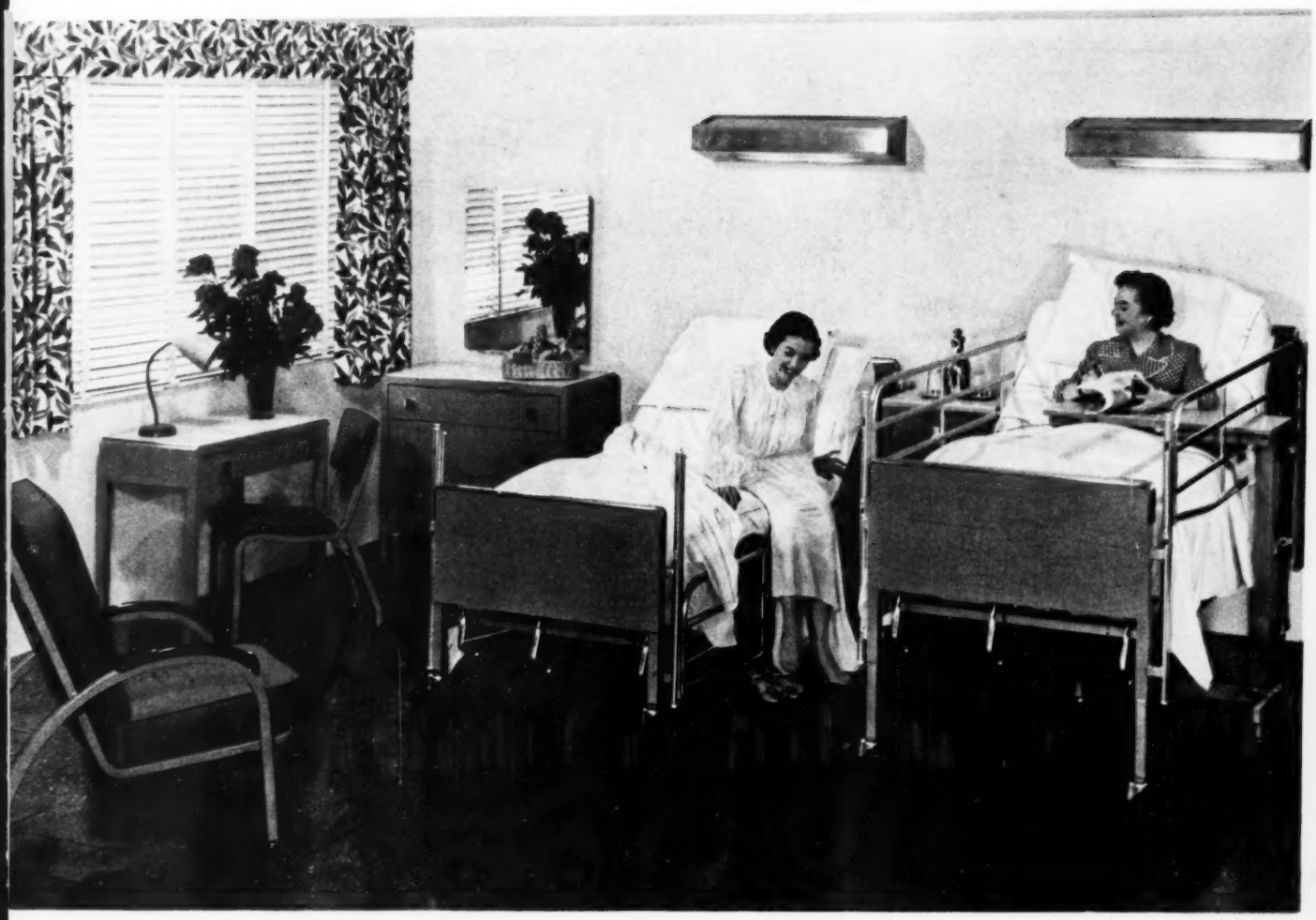
hospital officials announced the appointment of **Beatrice Rudnick** as assistant director of the nursing service department. A graduate of Bellevue Hospital School of Nursing, New York City, Miss Rudnick was previously assistant director of nursing service at St. John's Episcopal Hospital of Brooklyn.

Virginia Lovett, R.N., who has been assistant to the director of nursing at Good Samaritan Hospital of Puyallup Valley, Puyallup, Wash., has been named director of the department, succeeding **Gladys Bergum,** who has resigned.

Leone Franze, who has been superintendent of Brookings Municipal Hospital, Brookings, S.D., has become instructor in nursing education at Yankton State Hospital, Yankton, S.D.

Anna J. Kalmanowitz has been appointed director of nursing at Beth Israel Hospital, Boston, succeeding **Mary C. Gilmore,** who has retired after 18 years as head of nursing at Beth Israel.

Charles R. Gilliam, formerly office manager of the Methodist Hospital, Memphis, Tenn., has become controller of Rex Hospital, Raleigh, N.C. Mr. Gilliam is a member of the American



LOS ANGELES' FAMOUS

Cedars of Lebanon Hospital

SELECTS SIMMONS...OF COURSE

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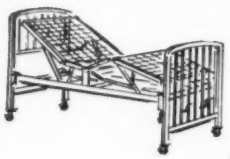

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Association of Hospital Accountants and of the Memphis Hospital Association and is a past member of the board of directors of the Tennessee Chapter of Hospital Accountants.

Helen A. Martin, director of nurses at Memorial Hospital, Springfield, Ill., has resigned. **Agnes Lapp,** who served as assistant director in charge of nursing service, has been appointed to the position of director of nursing service there, and **Helen Shull,** who served as assistant director in charge of nursing education, has been named director of nursing education at Memorial Hospital. Previously these two positions were combined.

Miscellaneous

Charles G. Roswell, chairman of the American Hospital Association commission on accounting, has resigned his position with the United Hospital Fund to accept a partnership in a public accounting firm that has specialized in hospital and institutional work. Mr. Roswell has been actively identified with hospital accounting for the last 25 years.

Martha Elizabeth Rogers, Sc.D., former research fellow at Johns Hopkins University, has been appointed chairman of the department of nurse education of the school of education at New York University. Dr. Rogers succeeds **Dr. Vera S. Fry,** who has joined the staff of the school of public health nursing at the University of California, Berkeley.

Dr. Roy T. Lester, who for the last four years has been engaged in private practice of thoracic surgery in Abilene, Tex., has been named director of Blue Cross and Blue Shield in Texas. He succeeds **Dr. S. P. Bliss,** who has resigned. Dr. Lester is a diplomate of the American Board of Surgery and Board of Thoracic Surgery and a fellow of the American College of Surgeons.

Deaths

Dr. J. G. William Greeff, who was New York City Commissioner of Hospitals from 1929 to 1933, died recently at Center Moriches, Long Island, N.Y. During the time he was hospital commissioner, he expanded New York's hospital system and was instrumental in widening ambulance service. A graduate of Columbia University College of Physicians and Surgeons, he was a member of the New York State Medical Society and of the New York Academy of Medicine.

Dr. Nathan Bristol Van Etten, former president of the American Medical Association and of the Medical Society of the State of New York, died recently at the age of 88. Dr. Van Etten was a graduate of Bellevue Hospital Medical College, now known as New York University - Bellevue Medical Center, and went into private practice in New York. In 1929 Dr. Van Etten became medical director of Morrisiana City Hospital, New York, and in 1932 was named president of its medical board. He was the first president of the Bronx Medical Society and in 1940-41 was president of the American Medical Association.

William A. Scott, assistant director of Passaic General Hospital, Passaic, N.J., died recently. He had been affiliated with Passaic Hospital in various capacities for many years.

Frank P. Rake Jr., assistant director of the Associated Hospital Service of Philadelphia, died recently at the age of 39. Mr. Rake was active in the initiation of the Blue Cross in Philadelphia in 1938. He was a member of the American Association of Hospital Accountants and of the National Office Management Association.

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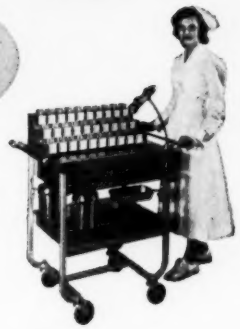

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Thus, after complete preliminary preparation of medication, with every dose identified by a card imprinted with name, room, medication, dosage and time, the nurse is ready to accomplish work in a single round that would ordinarily occupy the time of several nurses for a much longer period.

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THE BOOKSHELF

HOSPITAL PERSONNEL ADMINISTRATION. *By Norman Bailey. Chicago: Physicians Record Company. Pp.* 352. $7.50.

Hospital administrators today are aware of the need for improved personnel policies and the development of a good personnel department within their organization. Mr. Bailey makes available to the administrator a great deal of factual information in one compact book. He has a wide background of experience in the field of industrial and hospital personnel relations as well as the field of hospital administration. As a result he is well qualified to present this subject. While this is primarily a textbook, it should be a valuable addition to every hospital library. It is well organized and indexed for easy use, and contains an excellent list of reference works for those who wish to study any particular topic in more detail.

The subjects discussed range from the basic philosophy behind a personnel department to the detailed steps in organizing and operating such a department. The chapters on employe training, job analysis and evaluation, salary determination, and how to get along with or without unions should be of special interest to many administrators. One chapter is devoted to employe or merit rating plans. This field should be studied much more thoroughly before any formal program is established. Many leaders in industrial personnel relations are starting to reevaluate their thinking on the value of such plans.

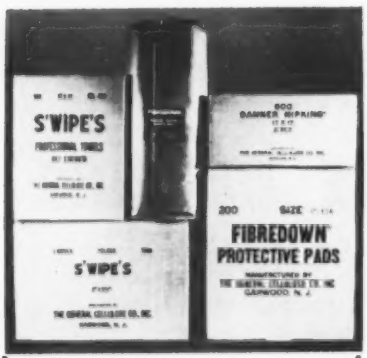
The author states that as a result of recent experience in smaller hospitals, he has made several changes in his original manuscript. He hopes that this will make it a more valuable piece of work for the administrator of the small hospital. It might have been much better if he had devoted one or two chapters entirely to the small hospital personnel problems. Many of the programs he has outlined are perhaps still too elaborate for a hospital of 100 beds or less and will need considerable modification.

Mr. Bailey has filled a long-vacant gap in the field of hospital literature and his book should be on the reading list for every administrator, assistant administrator, and personnel manager in the field.—ROBERT M. JONES.

PRINCIPLES OF PAYMENT FOR HOSPITAL CARE. *A pamphlet published by the American Hospital Association as a guide to hospitals and agencies which contract to purchase hospital care. Pp.* 16. *Chicago,* 1954.

Two nationwide conferences sponsored by the A.H.A.'s Council on Prepayment Plans and Hospital Reimbursement provided the groundwork for the publication of this excellent and timely report. The work of these conferences was revised and redrafted by the A.H.A. council and then approved by the house of delegates and the board of trustees.

An introductory comment by the executive director of the A.H.A., Dr. Edwin L. Crosby, says "The growth of



programs by which third party agencies pay hospital bills for a group of beneficiaries has raised important questions as to the amounts which should be paid to hospitals for care. Individual patients require different services and individual hospitals establish different regular charges for nominally similar service." Dr. Crosby points out that "any contract to provide service should protect a hospital's financial interest and its program of public service; payments should encourage high standards, administrative efficiency, institutional freedom and the rendering of service in the interest of patient welfare."

The report covers the following sections: (1) basis for payment, (2) determination of full cost, and (3) obligations in applying principles of full cost payment. The necessity of all third party payers paying full cost for hospital care contracted for by these third party payers is emphasized.

TWO OMISSIONS NOTED

An important consideration which seems to have been omitted from the chapter on determination of costs is a discussion of allowance for obsolescence, in addition to depreciation, as a cost factor. With present advances in scientific medicine, equipment is often obsolete long before it is fully depreciated. Just as industry recognizes the obsolescence factor, so should hospital costing. Another omission in this section is the failure to recognize the need of hospitals for operating capital. Many hospitals must carry large sums in accounts receivable. They cannot extend the credit which is so necessary to many of their patients unless they have sufficient operating capital to finance this credit. Inability of hospitals to grant credits means pushing many patients from a long-term, time payment, self-pay basis over into the medical indigent group.

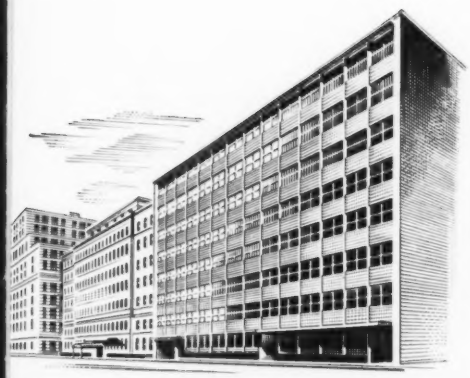
In discussing determination of costs it seems that the council should have recognized the often expensive emergency room services. Hospitals furnish many thousands of dollars of care to emergency room patients without any payment from any source. Everyone recognizes the absolute necessity of high-grade emergency room service, yet few seem to consider where the hospital will get the money to pay for this type of service. The same thing is, of course, true with reference to outpatient clinic services. Most hospitals have in the past included the cost of these two services in the rate charged bed patients who pay their own bill. Until the entire community, including city, county and township units of government, recognizes its obligation to pay for services rendered to people who can't possibly pay their own way in the emergency room and outpatient clinic, the hospital is forced to include these costs in rates charged bed patients. If self-pay patients must continue to bear a share of the cost of emergency room and outpatient clinic services, it would seem logical that third party payers should do the same thing.

CLARIFICATION NEEDED

In discussing income from endowment funds and gifts to hospitals the report states, "The general financial resources of a hospital do not relieve third party agencies of their responsibility of paying full cost for services provided." In this connection the relationship of community chests to hospitals needs clarification. In too many areas, community chests are paying hospitals for a given number of patient days, or for the maintenance of a given number of charity beds, at a rate far below cost. Whether community chests are providing gifts to hospitals, or whether they are in fact third party purchasers of hospital care, is a problem that should be studied.

The report states that the logical responsibility of the American Hospital Association is "the assumption of initiative in cooperation with appropriate agencies to develop objective criteria for evaluation of scope and quality of services of hospitals." It would seem that at this point the report should have clearly stated the responsibility of the Joint Commission on Accreditation of Hospitals and urged all hospitals to meet the standards of the joint commission.

This report is an important tool to help both the providers of service and third party payers gain a clearer understanding of the problems involved. Certainly, better understanding on the part of everyone will go far toward smoothing out the many and often petty arguments now involving both parties. Dr. Madison B. Brown, chairman of the A.H.A. Council on Prepayment Plans and Hospital Reimbursement, and all members of the council are to be congratulated on sponsoring the conferences resulting in this clear-cut, comprehensive report. —E. W. JONES.



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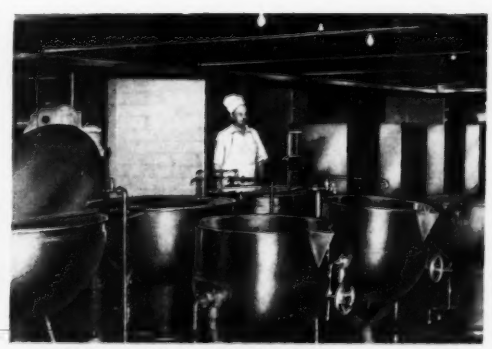

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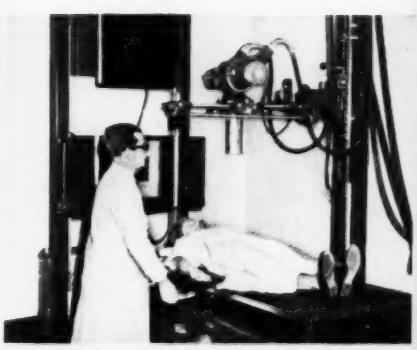

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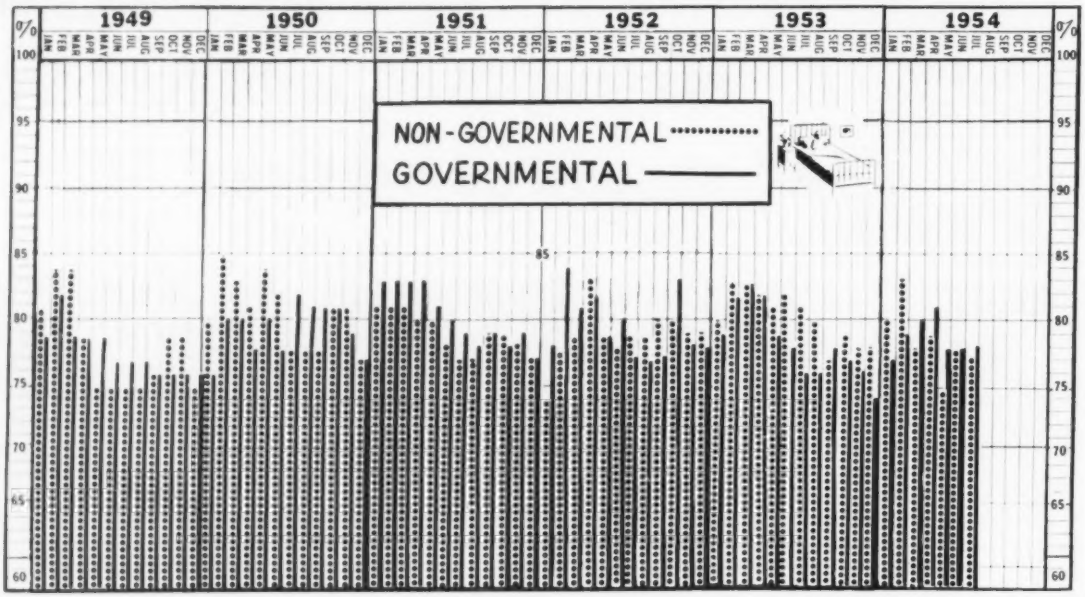

Governmental hospitals reporting to the Occupancy Chart for the month of July indicated an average daily occupancy of 77.9 per cent, and nongovernmental hospitals reported an average of 76.9 per cent. A year ago, they reported occupancy percentages of 76.4 and 78.5, respectively.

During the latest construction period, July 26 through August 9, new hospital building totaled $118,679,350, which brings the year's current total to $369,452,608. For the corresponding period of 1953, construction amounted to $141,582,385. One hundred and fifty-four projects were reported for the current period, of which 37 were hospitals.

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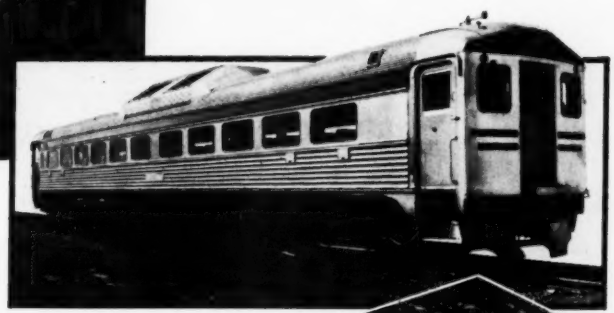

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PATHOLOGIST — Diplomate, FCAP; four years, director of pathology, 300-bed hospital and instructor in pathology, medical school; now completing two years' military service; age 33.

PERSONNEL DIRECTOR — A.B., considerable work toward MBA Personnel Management; six years' personnel experience.

PURCHASING DIRECTOR — B.S. Degree; eleven years, purchasing director, large teaching hospital.

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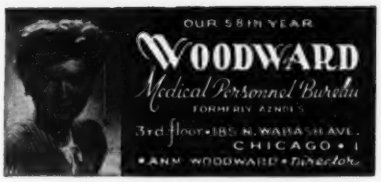
RECORD LIBRARIAN—B.A., Columbia; work toward Master's completed except for thesis; nine years, chief record librarian, 800-bed teaching hospital; recommended as "asset to any hospital."



ADMINISTRATOR—M.S. Hospital Administrator; year's hospital residency; 4 years, administrative duties; 100-bed hospital; seeks administration hospitals 100-200 beds or assistant administrator larger hospitals; very active in hospital affairs; middle 30's; MACHA.

ADMINISTRATOR — Medical: M.D. leading medical school; M.S. Hospital Administration; excellent experience includes 5 years, administrator 450-bed university hospital; MACHA.

ADMINISTRATOR—Assistant; 28; B.A.; M.S. Hospital Administration; 2 year's administrative residency university hospital.

ANESTHESIOLOGIST—Woman; M.D. Wisconsin University, School of Medicine; Certified Royal Canadian College Physician's and Surgeons; 15 years, private general and anesthesiological practice; can use any known machine; age 41; licensed Wisconsin; excellent references.

EDUCATIONAL DIRECTOR—R.N. University Hospital; A.M. Education; P.H. major; George Peabody College; 3 years private duty; 4 years teacher, first aid, nursing, hygiene; 6 years U.S. Army nurse, overseas; 4 years, nurse, superintendent, 500-bed hospital; consider teaching nursing arts, clinical instructor, assistant director of nurses; age 42; southerner, Baptist; single; prefer south, southeast or California.

PATHOLOGIST—Certified both branches; 6 years, residency; assistant and associate pathologist same 300-bed hospital; seeks directorship hospital laboratory; will teach; prefer smaller town, central or mountain states; 31; Category IV.

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RADIOLOGIST—33; M.D. Minnesota Medical; Diplomate, both branches; trained university hospital; 2 years chief radiologist, USAMC; 5 years, associate pathologist, 700-bed teaching hospital; now wishes head own department; outstanding references; any locality.

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BUSINESS MANAGER — Degrees, Business and Hospital Management; comptroller, investment corporation, 6 years; present position, 300 bed mid-western hospital.

(Continued on page 204)

INTERSTATE—*Continued*

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LAUNDRY MANAGER—1 year commercial laundry management; 5 years, 200-bed Ohio hospital.

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ADMINISTRATOR—Naples Memorial Hospital of Naples, Florida is about to begin construction on a 40-bed general hospital; is now ready to employ an administrator and will be glad to receive applications from interested applicants. Apply, Naples Memorial Hospital, 914 Fifth Avenue, South, Naples, Florida.

ADMINISTRATOR—Experienced; for new 50-bed voluntary crippled children's convalescent hospital to be opened in December; give complete personal history including education, professional experience, references and acceptable starting salary; all inquiries held confidential unless otherwise indicated. Apply by letter to Crippled Children's Hospital, Room 103, 1430 Tulane Avenue, New Orleans, Louisiana.

ADMINISTRATOR — Hospital administration graduates or experienced administrators; the new Lancaster Memorial Hospital is now considering applications for their hospital administrator. Direct all formal applications to Board of Trustees, B. J. Levin, Chairman, Lancaster, Wisconsin.

ANESTHETISTS—Nurse; for 150-bed general hospital; four nurses, full-time M.D., all agents and techniques; one month's vacation; two and one-half hours from Boston and New York. Write, G. J. Carroll, M.D., Chief of Anesthesia Department, William W. Backus Hospital, Norwich, Connecticut.

ANESTHETIST—Registered nurse; New 250-bed, well equipped general hospital; department directed by medical anesthesiologist, cooperative medical staff and personnel; good personnel policies; salary depends on experience, minimum $414.00 with periodic merit raises. Apply, Director, McLaren General Hospital, 401 Ballenger Highway, Flint 2, Michigan.

ANESTHETIST—New 100-bed general hospital; salary open; cooperative medical staff and personnel. Apply, Administrator, Mercy Hospital, Port Huron, Michigan.

ANESTHETISTS—Nurse—two; above average salary; medical anesthesiologist in charge. Apply, C. K. Shiro, Administrator, Montana Deaconess Hospital, Great Falls, Montana. Call at hospital expense.

ANESTHETIST—Nurse; to increase staff; approved AANA training school; good working conditions; medical anesthetist in charge of department. Apply, Director, Department Anesthesiology, Lancaster General Hospital, Lancaster, Pennsylvania.

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ANESTHETIST — Nurse; 250-bed non-profit general hospital; good salary and pleasant working conditions; five anesthetists employed; Apply, Administrator, Riverside Hospital, Newport News, Virginia.

ANESTHETIST — Nurse; Lutheran Hospital; 200-beds; 3 nurse anesthetists directed by anesthesiologist; starting salary $350.00 per month; paid vacation, holidays, sick leave, etc. Apply, Gundersen Clinic, La Crosse, Wisconsin.

ANESTHETIST—Nurse; for 250-bed general hospital; excellent working conditions and personnel policies; good starting salary. Write: Mr. Bert Stajich, Assistant Administrator, Columbia Hospital, 3321 North Maryland Avenue, Milwaukee 11, Wisconsin.

DIETITIANS—Therapeutic dietitians; Barnes Hospital, large teaching hospital; 3 units affiliated with Washington University School of Medicine; beginning salary $270 month; social security. Apply, Director of Dietetics. Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN — Therapeutic; for 400-bed fully approved Chicago Hospital; staff of 12 dietitians; 5-day week; duties include therapeutic diet planning, patient contact; help supervise student nurses; some tray checking on central tray service. Apply MO 85, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

DIETITIAN—Administrative; for 400-bed fully approved Chicago Hospital; to supervise pay cafeteria and to relive chief dietitian; staff of 12 dietitians; 5-day week. Apply, MO 86, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

DIRECTOR OF NURSING—For new 87-bed hospital for chronically ill which is combined with new 165-bed Home for the Aged; salary according to qualifications and experience. Apply, Mr. M. Rosenberg, Administrator, Jewish Home for the Aged, 3560 Bathurst Street, Toronto 12, Ontario, Canada.

DIRECTOR OF NURSING EDUCATION—B.S., capable of organizing and conducting a school of practical nursing; salary open; 40-hour week. Apply, Mrs. Marion G. Lamy, Superintendent, Moore General Hospital, Grasmere, New Hampshire.

DIRECTOR OF NURSING SERVICE—280-bed fully approved general hospital; must be qualified by preparation and experience; Degree required; full maintenance in comfortable living quarters; 40-hour week, salary open pending type of professional background; position available immediately. Apply, Administrator, Chester Hospital, Chester, Pa.

EDUCATIONAL DIRECTOR—200-student school, affiliated with Drake University; 400-bed, fully approved, non-profit hospital, includes 115-bed pediatric unit; desire person with M.S. Degree in Nursing Education, will accept B.S. with successful experience; work with select, enthusiastic, stable student body with predominately rural backgrounds; salary open, 40-hour work week, 22 working days vacation, sick benefits; position available immediately. Apply, Director of Nursing, Iowa Methodist Hospital, Des Moines, Iowa.

HOUSEKEEPER — Executive male; 700-bed general hospital; eastern city; assume responsibility for hospital, nurses residence, and living in quarters; must have ability to organize, supervise and train personnel in expanding organization; salary open. Apply MO 87, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

INSTRUCTOR—Clinical; surgical 295-bed general hospital; Degree required, experience desirable; 40-hour week, good personnel policies, salary commensurate with preparation and qualification of applicant. Apply, Director, School of Nursing, St. Luke's Methodist Hospital, Cedar Rapids, Iowa.

INSTRUCTOR—Clinical, in obstetrics; 332-bed hospital located in an attractive residential section; student body of 160; Degree in Nursing Education and some teaching experience preferred; salary range for 40-hour week, $320-$430; beginning salary commensurate with experience and preparation; liberal personnel policies; living accommodations available. Apply to Director of Nursing, The Toledo Hospital, Toledo 6, Ohio.

INSTRUCTOR — Clinical - Maternity; modern 400-bed hospital; student body of 100; good personnel policies; salary commensurate with positions. Apply, Director of Nursing, Kitchener Waterloo Hospital, Kitchener, Ontario, Canada.

(Continued on page 206)

classified advertising

POSITIONS OPEN

MISCELLANEOUS — Clinical Instructor and Supervisor for Pediatric Unit; 115-beds; 400-bed hospital; approximately 25 students assigned to unit every three months; B.S. Degree with major in Pediatrics or Nursing Education desired; total school enrollment 200 students; affiliated with Drake University. Apply, Director of Nursing, Iowa Methodist Hospital, Des Moines, Iowa.

MISCELLANEOUS — Operating Room Supervisor; 236-bed general hospital; also Nursery Head Nurse; 60-bassinets, in beautiful Santa Clara Valley; salaries open to qualified persons; pleasant working conditions; 40-hour week. Apply, Director of Nursing, San Jose Hospital, San Jose, California.

MISCELLANEOUS — Operating Room Supervisor, Head Nurse and Clinical Instructor; for 250-bed approved teaching hospital with small school of nursing; air conditioning and recovery room now being installed; qualified for administrative and teaching responsibilities; 40-hour week, paid annual vacations, holidays and sick leaves; Blue Cross, social security; salary open, depending on experience. Apply, Director of Nursing Service, Hospital of St. Anthony de Padua, 2875 W. 19th Street, Chicago 23, Illinois.

MISCELLANEOUS — Assistant Evening and Night Supervisors and Staff Nurses; for 250-bed approved teaching hospital with small school of nursing; liberal personnel policies; salary for supervisors depends on experience; beginning salary for staff nurses, 40-hour week; $300 a month; $15 differential for evenings and $10 for night duty; opportunity for advancement. Apply, Director of Nursing Service, Hospital of St. Anthony de Padua, 2875 W. 19th Street, Chicago 23, Illinois.

MISCELLANEOUS — Administrative Supervisors, pediatrics, psychiatry, and surgery; Teaching Supervisors, psychiatry, and orthopedic; salaries $350.00 to $390.00 per month. Instructor in neurologic nursing; Head nurses, surgery, birthrooms, nurseries, infectious pathologic and gynecologic, medicine, psychiatry, prematures and pediatrics. Salary $320.00 to $350.00 per month. Staff nurses, all clinical divisions; salary $300.00 to $320.00 per month; differential for afternoon and night duty $30.00 per month; forty hour week. Apply Director, Cook County School of Nursing, Dept. J., 1900 West Polk Street, Chicago 12, Illinois.

NURSES—General staff; for 350-bed general hospital; no obstetrics; center city location; 40-hour week; 3 weeks vacation; $220 monthly base gross salary; $20 monthly increment for 3-11 and 11-7 tour of not less than one month; 50% discount on tuition rates for University of Pennsylvania matriculation. University of Pennsylvania Graduate Hospital, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

NURSE—Head; delivery room; 332-bed general hospital with school of nursing; Degree and experience desired; 40-hour week, liberal personnel policies, living accommodations available, salary commensurate with qualifications; position available immediately. Apply, Director of Nursing, The Toledo Hospital, Toledo 6, Ohio.

(Continued on page 208)

NURSES—Graduate; positions open for two graduate nurses who either have, or are willing to obtain Colorado registry; floor duty, rotating shifts; starting salary $250.00 per month, 44-hour week; laundry furnished; under social security; two weeks paid vacation per year; high in the new Uranium country. Apply, MO 48, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSES—General staff; 250-bed general hospital and 72-bed maternity hospital; starting salary $280; $5 per month tenure increase for each six months of service to a maximum of $310; social security, sick leave, prepaid medical and hospital care; $10 additional for afternoon and night shift; $10 additional for delivery room; $20 additional for surgery; up to three weeks' vacation at end of 4 years; 7 paid holidays; 8-hour day, 40-hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, California.

NURSES—Operating room and obstetrical; California hospital on San Francisco Bay; forty minutes from that city; 5-day week; salary $275 per month if applicant has advanced preparation or experience; $10 additional for evening and night duty; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

NURSES—Operating room and staff; 100-bed general hospital; salary $280 per month; 40-hour week; $10 differential afternoon, night, and surgery duty; annual vacation and raises; 7 paid holidays, sick leave and free hospitalization and insurance. Apply, Director of Nurses, Mercy Hospital, 4001 J. St., Sacramento, California.

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POSITIONS OPEN

NURSES—Operating room; 300-bed hospital; 40-hour week; a'l cash salary; special consideration for experience and advance preparation; bonus for "on call"; liberal personnel policies, including social security, plus a retirement plan. Apply, Director of Nursing, Mercer Hospital, Trenton 8, New Jersey.

NURSES—Psychiatric; for a new psychiatric unit in a 700-bed hospital; excellent personnel policies. Write Mrs. Aileen L. Carroll, Director of Nursing, The Buffalo General Hospital, 100 High Street, Buffalo, New York.

NURSES — Psychiatric; for supervising psychiatric buildings and attendants; mature, experienced; $3,000 per year, board, room and laundry available at $480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

NURSES—Registered; new 200-bed hospital; starting salary of $270 and up, plus one meal and laundering of uniforms, increase after six months; good working conditions. Apply, Medical Center Hospital, Odessa, Texas.

NURSES—Registered; for operating room and general floor duty. Apply, Martinsville General Hospital, Martinsville, Virginia.

NURSES—Registered; a few positions for general duty and operating room nurses immediately available at The Waltham Hospital, Waltham, Massachusetts; hospital fully accredited; is situated in pleasant suburban location, eight miles from Boston; base rate of pay 40 hours; time and one half for overtime; average work week, 44 hours; automatic pay adjustment semi-annually for first two years; increased pay for evening and night shifts; social security, retirement plan, sick leave, paid vacations, paid holidays; living-in facilities available; ample opportunity for advancement for qualified employees. Apply to Director of Nursing in writing, or call WAltham 5-1630.

NURSES — Required by the Newfoundland Provincial Department of Health, General Hospital, St. John's, Newfoundland; applications are invited from registered nurses to fill the posts of general duty and operating room nurses at the 475-bed general hospital, St. John's; salary commences at $2000 per annum on the scale $2000-100-2100, less, either (1) $480 yearly resident or (2) $100 non-resident for meals provided on duty; uniforms and laundry services are provided and the working week consists of 44 hours; liberal personnel policies. Applications with full details should be addressed to the Director of Nursing, General Hospital, St. John's, Newfoundland.

NURSES—Staff; for hospital in college town; all registered staff; months paid vacation; two weeks sick leave; holidays; meals, laundry furnished. Apply, Superintendent, Allen Hospital, Oberlin, Ohio.

(Continued on page 210)

PATHOLOGIST — To head department; approved hospital in Pennsylvania. Address reply to MO 80, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

PHYSICAL THERAPIST — Registered; 160-bed general hospital in town of 24,000; modern facilities; salary commensurate with experience; good personnel policies. Write, Administrator, Waukesha Memorial Hospital, 725 American Avenue, Waukesha, Wisconsin.

SUPERVISORS — Operating room supervisor and assistant supervisor; salary open; complete maintenance if desired. Shriners' Hospital for Crippled Children, Philadelphia 15, Pennsylvania. MA 4-0700.

SUPERVISOR — Operating room nurse; wanted immediately for new surgical unit, 400-bed chest hospital, located outside of Buffalo, New York; maintenance available; state salary desired; liberal vacation and sick leave; State pension system. Apply, Director, J. N. Adam Memorial Hospital, Perrysburg, New York.

SUPERVISOR—Operating room; Northwest; 450-bed general hospital, new modern 11-room operating room suite; 40-hour week; $6000 for well qualified and experienced person; please state education and experience; liberal personnel policies. Apply MO 55, The Modern Hospital, 919 North Michigan Avenue, Chicago 11.

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POSITIONS OPEN

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1030

PALMOLIVE BUILDING CHICAGO

ADMINISTRATORS: (a) One of country's leading hospitals operated by important university as its teaching hospital; preferably one who has demonstrated capacity to administer large hospital. (b) Medical superintendent well qualified in medical education; 700-bed general hospital; associate administrator under supervision of medical director will handle business administration; Pacific Coast. (c) Associate medical director, large teaching hospital; midwest. (d) Voluntary general hospital, 225-beds; administrative experience required; $16-$20,000; residential town, east. (e) Director, medical center; present bed capacity 600; expansion program; college town, east; $18,000. (f) New general hospital, 250-beds, currently under construction; completion October; preferably one available for completion of construction, purchasing, organizing of staff; south. (g) Assistant administrator, university hospital operated under American auspices, foreign country; major duties: training hospital administration students. (h) Assistant; minimum three years' administrative experience; accounting background required; 250-bed general hospital; $7500-$8000. MH9-1

ADMINISTRATORS (Women): (a) New general hospital, 50-beds, resort town on Gulf of Mexico. (b) General, 100-bed hospital; college town; east. MH9-2

ANESTHETISTS: (a) Two; new, voluntary, general hospital, 350-beds; department directed by medical anesthesiologist; educational center, south; $4900-$5700. (b) To administer anesthetics for surgical department, 14-man group; no obstetrical anesthetics; college town near large city, medical center, midwest; month's vacation annually; minimum, $7200. (c) Voluntary general hospital, 400 beds; university city, hour's ride from New York City; $500. MH9-3

DIETITIANS: (a) Chief; university hospital, 300-beds; plans completed for new medical center including hospital of considerably greater capacity; midsouth. (b) Chief, new 400-bed hospital recently opened for operation, unit university group; medical center; southwest; minimum $6000. (c) Dietitian to share time between two hospitals located in resort town, 18 miles apart; midwest. (d) Chief, voluntary general hospital, 300-beds; staff of 55; university town, east; opportunity continuing studies. MH9-4

(Continued on page 212)

DIRECTORS OF NURSING: (a) General hospital, 600 beds, affiliated medical school; privilege of selecting own assistants; $10,000. (b) Head, department of nursing, college for young women; east. (c) Collegiate school; three-year diploma and four-year degree; medical center; south. (d) Director of nursing service; preferably Master's; hospitals of large medical center. (e) Assistant director of nursing service, fairly large general hospital; outside United States. (f) Nursing service only, one of California's leading hospitals. (g) Nursing service; voluntary general hospital, 200-beds; delightfully located in leading city, foreign country. MH9-5

EXECUTIVE HOUSEKEEPER: General, 200-bed hospital, university town, Pacific Coast. MH9-6

EXECUTIVE PERSONNEL: (a) Food service manager qualified take complete charge of department, teaching hospital, 350-beds; staff of 100 including eight dietitians. (b) Comptroller to reorganize and head department, 600-bed, teaching hospital; expansion program; $10-$12,000. (c) Personnel director, teaching hospital, 800 beds; midwest. (d) Purchasing director; extensive experience on administrative level required; large teaching hospital; east. MH9-7

FACULTY APPOINTMENTS: (a) Director, four-year degree program in nursing being established by state university. (b) Educational director and clinical instructors in medicine and surgery, 300-bed general hospital; vicinity New York City. (c) Educational

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POSITIONS OPEN

MEDICAL BUREAU—*Continued*

director, clinical coordinator, clinical instructors, medicine, surgery, pediatrics; new hospital, 350-beds; college town; south. (d) Teaching supervisors in pediatrics and obstetrics and nursing arts instructor; voluntary, general hospital; large city outside United States. (e) Educational directors and instructors, South America; knowledge Spanish, French or Portuguese. (f) Pediatric instructors for Brazil, India; psychiatric instructor for Brazil; nursing arts instructor for Jordan. MH9-8

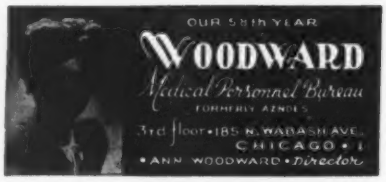
MEDICAL RECORD LIBRARIANS: (a) Chief; large, teaching hospital; qualified reorganize department; outstanding opportunity; east. (b) Voluntary general hospital, 200-beds; interesting city; Pacific Islands. (c) Chief; qualified take complete charge of department and assume responsibility of supervising six staff members; voluntary general hospital, 350-beds; university town, Pacific northwest. MH9-9

STAFF AND SURGICAL: (a) New, completely air-conditioned, 300-bed hospital, staff of outstanding specialists, medical center; opportunity for continuing studies. (b) Two surgical, two staff; small general hospital; resort town, San Joaquin Valley. MH9-10

SUPERVISORS: (a) Operating room supervisor; voluntary general hospital, 350-beds, service predominantly surgical; medical center, midwest; $5000. (b) Obstetrical; new

MEDICAL BUREAU—*Continued*

voluntary general hospital, 300-beds; resort city, offering facilities two universities near New York City. (c) Pediatric and obstetrical; large general hospital, modern in every way, university city outside United States, although tropical country, climate mild and pleasant. (d) Psychiatric and pediatric supervisors; new 500-bed hospital, unit, university group; west. MH9-11



ADMINISTRATORS — (a) Lay; important medical center; 2 units; 400-beds; teaching program; residential town 40,000 near metropolis; east. (b) Medical; assistant; prefer one well trained in surgery; small hospital; very busy surgery department; $20-$25,000; California. (c) Lay; general hospital in last stages construction; 250-beds; immediate appointment; college town 100,000. (d) Medical director; general hospital 500-beds; medical school affiliation; $15-$20,000; west. (e) Lay; general voluntary hospital large size; $18,000; east. (f) Medical; important teaching hospital very large size; large city; important

(Continued on page 214)

WOODWARD—*Continued*

medical center; $14-$17,000; east. (g) Lay; voluntary general hospital 150-beds; university medical center; east. (h) Medical director; State school; large size; midwest. (i) Lay; voluntary general hospital 150-beds; college town 100,000; midwest. (j) Lay; new Hill-Burton hospital 125 beds; college town near important university metropolis; south. (k) Lay; one of finest hospitals in area; cooperative board; excellent medical staff; 100 miles from Chicago. (l) Lay; voluntary general hospital 70 beds; near university city; southwest. (m) Assistant and public relation officer with good accounting background; cost control experience helpful; general hospital 75 beds; $5000; large city; university medical center; south.

ADMINISTRATOR — Woman; (a) Tuberculosis hospital 75-beds; church affiliation; requires capable administrator prefer Episcopalian; $5000 plus full maintenance including 6 room apartment; large city. (b) Voluntary general hospital 150-beds; $8-$10,000; large city; important university medical center; east. (c) Assistant; requires R.N. with B.S. in Nursing and M.S. in Hospital Administration; will assume full charge later; voluntary general hospital 130-beds; Blue Ridge Mountains; southeast.

ANESTHETISTS — (a) Voluntary general hospital 350-beds; good salary and excellent personnel policies; tropical island of U.S. dependency, lovely climate. (b) Small general hospital; salary and call should net $7-$9000; large city; midwest. (c) 350-bed teaching hospital; very desirable city; east.

CHILDREN'S MEDICAL CENTER
Austin, Texas

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Fehr & Granger

Acoustical Contractor:
Calcasieu Co.

A colorful décor and attractive, durable furnishings help to make this children's waiting room pleasant as well as practical. The sound-absorbing ceiling of Cushiontone also contributes to the cheerful, relaxing atmosphere.

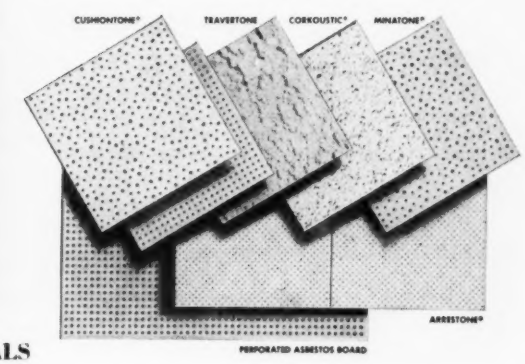
Medical Center combines color and quiet to make children more comfortable

Guided by the therapeutic effect of color, Children's Medical Center decorated their waiting room in bright, primary hues. To keep the room pleasantly quiet, an acoustical ceiling of Armstrong's Cushiontone was installed. This cleanly perforated, wood-fiber material absorbs up to 75% of the noise that strikes its surface.

Two factory applied coats of white paint on both face and bevels give Cushiontone high light reflectivity as well as a smart appearance. And Cushiontone's surprisingly low cost makes it especially suited for a limited budget.

Get full details on Cushiontone and Armstrong's entire line of sound-conditioning materials from your Armstrong acoustical contractor. For the free booklet, "How to Select an Acoustical Material," write Armstrong Cork Company, 4209 Union Street, Lancaster, Pennsylvania.

Only simple and infrequent maintenance is required to keep this noise-absorbing Cushiontone ceiling clean and new looking. Laboratory tests show that Cushiontone can be washed or repainted as often as necessary without loss of efficiency.



ARMSTRONG'S ACOUSTICAL MATERIALS

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POSITIONS OPEN

WOODWARD—*Continued*

DIETITIANS — (a) Food service manager; 140-bed hospital; one of best equipped and modern diet departments in southwest; minimum $6000; university city. (b) Voluntary general hospital 150 beds; to $5400; Florida. (c) ACS approved 500-bed general hospital; town 30,000; Canada.

DIRECTOR OF NURSES — (a) Nursing service and education; fully approved 500-bed general hospital; outstanding salary; east. (b) 190-bed tuberculosis hospital; minimum $6500 and full maintenance; city 120,000; midwest. (c) Nursing service and education; very large teaching hospital; 275 students; full faculty rank; to $8000; university medical center; middle east. (d) Nursing service and education; outstanding teaching hospital; important medical school; $7-$9000; university medical center; east.

EXECUTIVE HOUSEKEEPERS — (a) Fully approved 250-bed voluntary general hospital; $4800; university medical center; midwest. (b) Newly established 225-bed hospital; university city middle east. (c) General hospital 275-beds; summer resort town; New England.

FACULTY APPOINTMENTS — (a) Education director; 200 students in temporary NLNE accredited school; 300-bed voluntary hospital; $5400; state capital; south. (b) Nursing arts instructor; 200-bed general hospital; Bay area, California. (c) Clinical instructor in obstetrics; 160 students; 330-bed hospital; university city 300,000; middle east. (d) Science instructor; 45 students; general hospital 250-beds; to $4800; attractive town 40,000; midwest.

PUBLIC HEALTH—Nursing director; duties include planning, promoting and supervising city wide public health nursing work; $6500; desirable city; Michigan.

SUPERVISORS — (a) Delivery room; 225-bed special hospital; to $4200; Pacific Island. (b) For new pediatrics division of 11 beds; voluntary general hospital 200 beds; Los Angeles area. (c) Operating room; 500-bed teaching hospital; $6000; university city; Pacific Northwest.

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

COMPTROLLER—Middle west; 400-bed hospital; require at least 3 years of accounting or business management experience; one year in supervisory capacity. $7000.

DIRECTOR OF NURSES—(a) Middle west; 100-bed hospital with expansion program under way to increase to 200 beds within 2 years; no nursing school. $7200. (b) East; 210-bed hospital; excellent school of nursing; ideally located in medium sized town close to several large cities. $6000 minimum. (c) East; 225-bed hospital located in beautiful suburban area within commuting distance of New York City; require at least 5 years' experience. $6000-$7200. (d) Assistant; middle west; 130-bed hospital; present director is retiring and assistant will become director within 6 months to a year; $4800. (e) South; 150-bed hospital in city of about 65,000; $6000.

EXECUTIVE HOUSEKEEPERS—(a) West; 300-bed general hospital, fully approved; dry, moderate climate; $4800. (b) South; 500-bed hospital located in progressive southern city; 75 employees in department; $4200; minimum. (c) Middle west; 220-bed hospital; new ultra modern; located in lovely residential section of large city; 47 employees in department; $5000 plus maintenance. (d) Middle west; large teaching hospital; 160 employees in department; 5 supervisory housekeepers. (e) Southwest; 250-bed hospital; more than 50 employees in department; $4800.

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATORS — (a) 60-bed hospital, Virginia. (b) 75 bed Ohio hospital. (c) 45 bed Iowa hospital. (d) Business manager, 200 bed eastern hospital.

(Continued on page 216)

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POSITIONS OPEN

INTERSTATE—*Continued*

ASSISTANT ADMINISTRATOR — (a) Experienced; Degree in Hospital Administration preferred; 375-bed hospital, Ohio. (b) Nurse; college degree required. 375-bed hospital, midwest. (c) Orthopedic hospital. (d) Credit-office manager; Ohio; West Virginia.

NURSE SUPERINTENDENTS — (a) Small mid-western hospitals. (b) Directors nursing service.

EXECUTIVE HOUSEKEEPER — (a) 350-bed hospital; east. (b) 150-bed Illinois hospital. (c) 275-bed New England hospital. (d) Teaching hospital; Ohio.

LABORATORY X-ray Technicians—(a) 35-100 bed hospitals; southwest. (b) Chief laboratory technician; 100-bed Ohio hospital; $375. (c) Pharmacists; $350-$500. (d) Record librarians; to $375, maintenance. (e) Chief dietitian, 350-bed Ohio hospital; $5,000. (f) Therapeutic dietitians; attractive locations.

MEDICAL PERSONNEL EXCHANGE
Nellie A. Gealt, R.N., Director
311 Land Title Building
Philadelphia 10, Pennsylvania

PHYSICAL THERAPIST — Large university student health department; required also to teach one course; $3600 plus maintenance; 40-hour week; liberal personnel policies.

MEDICAL PERSONNEL EXCHANGE —*Continued*

RESIDENT PHYSICIANS — (a) Male or female; large school; research and diagnostic work; salary open, will be good; family maintenance available. (b) 200-bed convalescent hospital; older man preferred; $4200 plus family maintenance.

MEDICAL RECORD LIBRARIANS — (a) 492-bed general hospital; start $450. (b) 145-bed hospital; registration not required; $250 plus full maintenance. (c) Assistant; 500-bed hospital; start $4000; all three positions are on 5 day, 40-hour week.

REFERENCE LIBRARIAN—School of nursing large hospital; 40-hour week; salary open.

SOCIAL DIRECTOR—Nurses training school; 375-bed hospital; Physical Education major; 40-hour week.

PUBLIC HEALTH COORDINATOR — 300-bed general hospital; B.S. Degree or certificate in Public Health Nursing plus experience; 5 day, 40-hour week.

DIRECTOR OF NURSING SERVICE—To act also as assistant superintendent; 75-bed hospital New York City area.

RESIDENT NURSE—Girls' college; beautifully located on a 60 acre campus; No age limit; start $200 monthly plus full maintenance.

(Continued on page 218)

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Mary A. Johnson, Ph.D., Director

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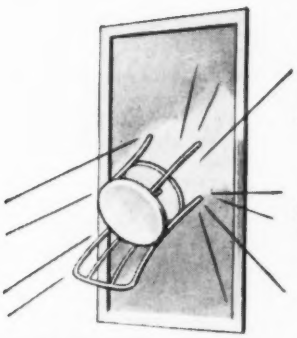

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Made of high-tensile, stainless-steel screening, Chamberlin Detention Screens resist usual forcing, prying, picking, and abuse by patients. Let Chamberlin's nation-wide Screen Advisory Service advise you on the selection and installation of security screens to suit your exact needs. Detention, Protection, and Safety types. No obligation. Write today.

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Special Products Division

1254 LA BROSSE ST. • DETROIT 32, MICHIGAN

Protect patients! Spring action (shown in jump test) protects patients who hurl themselves at screen. Screening gives under blows . . . absorbs shock, lessens injury to patient, damage to screen. Degree of tension adjustable.

Stop glass breakage! Installed on inside window frames or walls, Chamberlin Detention Screens eliminate broken glass . . . pare maintenance bills way down and safeguard patients, too. Also double as insect screens.

Control clutter! Close-woven Chamberlin Screens permit plenty of light and air, yet keep articles from being passed in, litter from being thrown out. Grounds stay cleaner with less need for costly maintenance.

Permit release in case of fire! New, exclusive Chamberlin Emergency Lock greatly reduces peril of fire. Special device opens screens *from outside* for emergency removal of patients. Lock optional at no extra cost.

Chamberlin Institutional Services

also include Rock Wool Insulation, Metal Weather Strips, All-Metal Storm Windows and Insect Screens

classified advertising

PLACEMENT BUREAUS

THE MEDICAL FIELD
EMPLOYMENT AGENCY

790 Broad Street—cor. Market
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A MEDICAL AGENCY specializing in placements for Industry, Pharmaceutical Houses, Doctors' Offices and Institutional help.

Eleanor M. Mangini, R.N.
Director

ZINSER PERSONNEL SERVICE
Anne V. Zinser, Director

Suite 1004—79 West Monroe Street
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We have many good openings for Directors of Nurses, Instructors, Supervisors, Dietitians, Medical Technicians, Record Librarians and Staff Nurses. If you are looking for a position, please write us.

PLACEMENT BUREAUS

INDIANA MEDICAL BUREAU
212 Bankers Trust Bldg.
Indianapolis, Indiana

Opportunities in most areas for Administrators, Medical Directors, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Laboratory and X-Ray Technicians, Therapists, Medical Records Librarians, and all areas of supervisory hospital and medical personnel.

MISCELLANEOUS

HOSPITAL NURSING CONSULTANT
BUREAU OF HOSPITAL FACILITIES
MISSOURI STATE DIVISION OF HEALTH

A nurse experienced in hospital nursing service, or nursing education. Bachelor Degree required. Attractive salary, generous mileage and expenses while traveling within the State. Write to: Mr. John D. Paulus, Jr., Director, Bureau of Hospital Facilities, Division of Health, State Office Building, Jefferson City, Missouri.

(Continued on page 220)

MISCELLANEOUS

SALES REPRESENTATIVES WANTED

Largest manufacturer in United States of plastic mattress covers has several hospital territories open for sales representatives to handle as additional line. Attractive commission basis. Protected territories. Monthly settlements. Write in confidence.

Philmont Manufacturing Co.
Dept. D, Englewood, N. J.

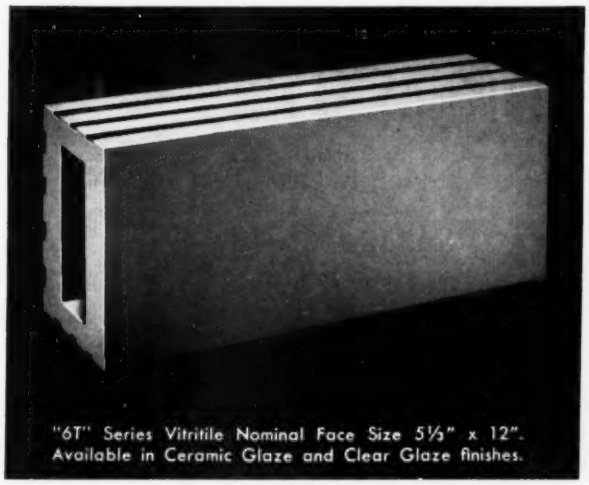
FOR SALE

A beautiful location for a private hospital or similar institution in Lancaster County, Pennsylvania, overlooking the Susquehanna River; on a tract of 5½ acres, high ground, secluded, but within borough limits. Large three-story, brick, 17-bedroom, main building; 11-room owner's residence; swimming pool. Ample space for expansion. Contact W. K. MacCorkle, 601 E. Darby Rd., Havertown, Pa.

NATCO
structural ceramic glaze
VITRITILE
for hospital walls and partitions

No other building material offers so many service advantages

St. Vincent's Hospital, Toledo, Ohio.
Architects—Maguolo & Quick. Contractors—A. Bentley & Sons.



"6T" Series Vitritile Nominal Face Size 5⅓" x 12".
Available in Ceramic Glaze and Clear Glaze finishes.

Winnebago State Hospital, Winnebago, Wisconsin. Architects—
Auler, Irion & Wertsch. Contractors—George A. Fuller Co.

There is a logical reason why NATCO structural ceramic glaze Vitritile has been and is being used successfully in the construction of so many hospitals throughout the country. It is because NATCO Vitritile meets fully the definite requirements of hospital walls . . . the features you want most . . . permanence, minimum maintenance, fireproof, lifetime beauty, utmost sanitation, germ and vermin proof, good visibility, restful colors. All of these are provided by NATCO structural ceramic glaze Vitritile. It is ideal for walls and partitions of wards, private rooms, corridors, kitchens, lavatories, showers and operating rooms.

This desirable building material builds strong load-bearing walls and durable color engineered interior finish *in one operation.* Modular in design, Vitritile is available in a complete line of shapes and fittings that make it adaptable to either modular or conventional layout with a minimum of cutting and waste on the job. Thus erection costs are low. There is no maintenance except occasional washing with soap and water.

Above all, Time's record of actual installations prove NATCO structural ceramic glaze Vitritile to be *lowest in cost.* Write for more detailed information.

17 Strategically Located Clay Plants

NATCO CORPORATION

General Office: 327 Fifth Avenue, Pittsburgh 22, Pa.

DISTRICT SALES OFFICES

Boston • Chicago • Detroit • New York • North Birmingham
Philadelphia • Pittsburgh • Syracuse • Toronto

The Quality Line Since 1889

classified advertising

FOR SALE

Completely equipped ten bed hospital including beds, stands and bedside tables, complete nursery with three bassinets, two incubators, complete obstetrical room, surgery with all instruments, x-ray room with portable x-ray, linens, gauzes and bandages, and all other general and miscellaneous equipment. Cause of sale: death of doctor-owner. All equipment in excellent condition ready to use. Also stoves, refrigerators and deep freeze if desired. Apply MS 6, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

HARRY D. WELLS
400 East 59th Street, New York City

NURSING AND MEDICINE

We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

FOR SALE

FOR SALE or LEASE—SMALL GENERAL HOSPITAL. 19-beds, completely equipped; registered; 8 doctors on staff; 500 patients per year; resort town; East coast. Sunny South Hospital, Edgewater, Florida.

SCHOOLS—SPECIAL INSTRUCTION

WOMAN'S HOSPITAL, Detroit, Michigan, offers a four months' clinical course in obstetric nursing to qualified professional nurses. Full maintenance and a monthly stipend of $100.00 allowed. Classes enter October 5, 1954 and March 1, 1955. For further information apply—Director of Nurses, 432 E. Hancock Avenue, Detroit 1, Michigan.

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Ill.

SCHOOLS—SPECIAL INSTRUCTION

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Missouri.

SKIDMORE COLLEGE offers a one-semester program to graduate nurses in operating room nursing and unit management. For details write Chairman, Department of Nursing, Skidmore College, 303 E. 20th St., New York 3, N.Y.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $60 a month provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

for handsome design...

for profitable operation

Wheeler's uses Libbey Crested Heat-Treated Glasses

Iced Tea, No. 606
12 oz.

Water, No. 610
9½ oz.

One look through the big picture windows indicates it. Closer inspection inside, proves it: Wheeler's, Indianapolis, Indiana, is an outstanding food operation. Popular owner William O. Wheeler knows the value of top-grade food, service and equipment.

When it came to glassware Mr. Wheeler demanded, and got the best: Crested Heat-Treated tumblers in Libbey's popular Governor Clinton line. Mr. Wheeler liked the unbeatable Libbey combination of handsome design, easy-to-hold shape, long wearing durability. And, not to be overlooked is the money-saving combination of Heat-Treating and the Libbey "Safedge" guarantee.

A Libbey Heat-Treated glass averages up to 200 servings at a cost per serving of only a fraction of a mill. Every Libbey glass is further guaranteed: "A new glass if the rim of a Libbey 'Safedge' glass ever chips!"

You can bring the same good taste and operating economies to your own beverage service. And for a slight additional cost, you can include the personal touch that your own crest, monogram, or trade mark brings.

• • •

Investigate today. See your Libbey Supply dealer, or write to Libbey Glass, Division of Owens-Illinois Glass Company, Toledo 1, Ohio.

LIBBEY HEAT-TREATED GLASSWARE
AN (O) PRODUCT

OWENS-ILLINOIS
GENERAL OFFICES · TOLEDO 1, OHIO

LOOK AT

KITCHEN EQUIPMENT

Are you going to remodel your dietary department this summer? Planning a new or expanded kitchen and food service layout? Then you will most certainly need catalog information on food service equipment. Turn to section B in the 31st Edition of Hospital Purchasing File now in your office (A recent survey shows that HPF is in nearly every U.S. hospital—that it is kept in the office of the administrator or purchasing agent). You'll find cooking equipment, food preparation machines, dishwashers, heated carts, dinner ware, garbage disposal equipment, tables and seating for dining rooms—virtually everything you'll need in planning a new dietary department or in making over your present facilities. Call in your dietitian, let her learn how to find needed catalog information first in HPF. And be sure all your other department heads are thoroughly familiar with HPF, too. Be sure you always turn first to HPF when buying information is required. See what the manufacturers (listed at the right) have to offer.

Here are the catalogs in Section B:

Aatell & Jones, Inc.
American Cyanamid Co., Plastics Dept.

Blickman, Inc., S.
Blodgett Co., Inc., The G. S.
Boonton Molding Co.

Cleveland Range Co.
Cunningham Co.

Flex-Straw Corp.

Gifford-Wood Co.
Gumpert Co., Inc., S.

Hotpoint Co.

International Silver Co., Hotel Division

Libbey Glass Division of Owens-Illinois Glass Co.
Lily-Tulip Cup Corp.

McDonald Company
Market Forge Co.
Mealpack Corp., Subsidiary of American Hospital Supply Corp.

Metropolitan Wire Goods Corp.

National Store Fixture Co., Inc.
Norris Dispensers, Inc.

Pick-Edmunds & Co.
Prometheus Electric Corp.

Savory Equipment, Inc.
Swartzbaugh Mfg. Co.

Toastmaster Products Division, McGraw Electric Co.
Toledo Scale Co.

Universal Dishwashing Machinery Co.
Universal Industries

Van Range Co., John, Division of The Edwards Mfg. Co.

Washburn & Granger, Inc.

ESTABLISHED AS THE HOSPITAL YEAR BOOK IN 1919 BY THE MODERN HOSPITAL PUBLISHING CO. INC.

PURCHASING FILES, INC.

919 N. MICHIGAN AVE., CHICAGO 11, ILL.

X-ray course that brings you long-range benefits

YOU'LL never visit the classroom above. But the instructor is passing along information that means greater day-to-day efficiency for your x-ray operation.

He's a member of General Electric's Engineering Service staff, bringing a group of field servicemen up-to-date on the latest developments in the installation, operation and maintenance of G-E apparatus. In addition, he's one of the men at the factory who gets a telephone call if an unusual service problem is encountered on your x-ray equipment.

Available through the X-Ray Department's local district offices, with headquarters at Milwaukee 1, Wis., General Electric's Engineering Service is just one example of how you get much more than equipment when you buy G-E x-ray apparatus.

Progress is our most important product

GENERAL ELECTRIC

6

of the many extra services you get from General Electric X-Ray

(1) INSTALLATION PLANNING SERVICE . .	Expert layout of your complete x-ray facilities down to the last detail.
(2) TECHNICAL SERVICE	Operative technical experience available on latest technics and procedures.
(3) EMERGENCY SERVICE	Day or night — fast, factory-trained service and quality repair parts at your call.
(4) ENGINEERING SERVICE	Field service personnel are kept up-to-the-minute on latest equipment advances.
(5) MAXISERVICE®	You can *rent* G-E x-ray apparatus. No initial capital outlay, no obsolescence risk.
(6) SUPPLY SERVICE	Extensive local stocks of x-ray accessories and supplies at 68 field offices.

What's New for Hospitals

SEPTEMBER 1954 Edited by BESSIE COVERT

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 256. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Increased Usable Space in Square Sterilizer

A complete new line of square sterilizing equipment is being introduced for hospital use. The American Square Sterilizer is designed to provide 35 to 100 per cent increase in usable sterilizer loading capacity. The increased loading capacity without increased maintenance or increase of occupied floor space saves labor and steps in loading and unloading, then reloading for an additional cycle.

All sizes and types of sterilizers in the American line are available in the new square design. The Square Sterilizer will be available in the recessed mounting as well as the new cabinet mounting. Wherever open-mounted equipment is installed the new American Sterilizer Stainless Steel Cabinet reduces heat, saves floor space and provides economy of installation, combining the advantages of recessed and open-mounted equipment. **American Sterilizer Co., Erie, Pa.**

For more details circle #418 on mailing card.

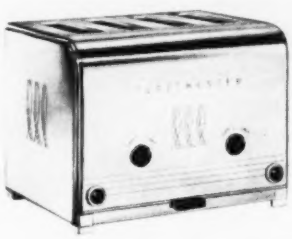
Pre-Cut Turkeys for Institutional Use

Kitchen time and labor are saved with the new pre-cut turkeys now being made available for institutional use. Better portion control is possible with the new system and cooking time and stove space are saved. Each new pack contains a complete large tom turkey cut into its basic parts for easier and quicker cooking. The whole turkey or selected parts may thus be cooked on top of the stove or in the oven. Parts are separated into pieces to be poached and pieces to be simmered. Storage space is also saved with the new method of packaging. **The National Turkey Federation, P. O. Box 69, Mount Morris, Ill.**

For more details circle #419 on mailing card.

Powermatic Toaster Operates With No Manual Action

A truly automatic toaster is now available which requires no manual action for operation, once it is plugged into the power source and set for the desired toasting. Bread is merely dropped into the slots, the motors automatically lower it, start the toasting and serve up the finished piece of toast. The new "Superflex" toast-timer automatically compen-



sates for normal voltage fluctuations and assures perfect toast on every operation whether the toaster is cool, warm or hot. The combination toast selector and release dial provides a choice of light, dark or in-between toast. The toasting action may be interrupted at any time by simply pressing the selector dial.

Red signal lights indicate to the operator which toasting slots are actually in use. The Powermatic Toaster Model 1D5 can toast four slices at one time and has a capacity of 250 slices per hour. It is economical to operate since current is used only while bread is actually toasting. The modern, streamlined design with chrome finish and black bakelite dial is attractive in appearance and easy to keep clean. The new toaster is constructed for years of trouble-free service. **Toastmaster Products Division, McGraw Electric Co., Elgin, Ill.**

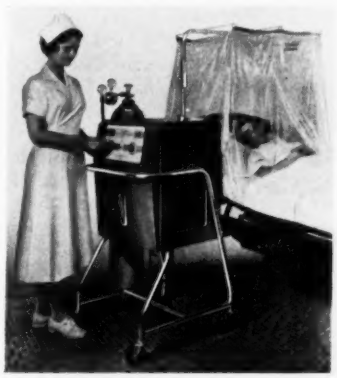
For more details circle #420 on mailing card.

(Continued on page 226)

Three Frame Heights Available in Oxygen Tent

The Ohio Model 25 Electric Oxygen Tent is available in three different frame heights to accommodate all bed rails. Rails cannot block the opening into the hood and the illuminated instrument panel is located at a convenient height. The modernly designed, lightweight, compact unit is mounted on a Steril-Brite aluminum handle bar frame with 4 inch ball bearing swivel conductive casters for easy mobility. The canopy support folds flat against the cabinet for movement or storage.

Non-varying temperature and humidity conditions are maintained inside the hood of the new tent. The non-cycling refrigeration unit runs continuously at a low noise level. The modulating temperature valve has a single selector knob on the control panel. A large slow-speed blower, completely separated from the motor shaft, achieves oxygen economy and the shaft can be sealed against oxygen leakage. The all aluminum chamber is insulated and has neoprene-coated joints. The cooling chamber is an integral part of the hood and has no intervening ductwork. Higher oxygen concentrations are possible in the hood with these features. The radiator is located above the dust-lint zone and is readily accessible for cleaning. The permanent aluminum filter can be washed



in soap and water to remove trapped lint and dust. **Ohio Chemical & Surgical Equipment Co., Madison 10, Wis.**

For more details circle #421 on mailing card.

What's New . . .

Selective Temperature Control for Existing Buildings

A newly developed thermostatic system of automatic and selective temperature control on an individual room basis is now available for existing hospital buildings. The new Honeywell Round control system consists of a simplified electric radiator valve, a miniature transformer and the new "round" thermostat. It can be installed room by room, as the hospital budget permits, requiring no structural changes and even without disturbing patients in the room. The desired temperature can be set in each room, the individual control compensating for the varying effects of wind, sun, open windows and other temperature factors.

The new system can be used with any type of heating system or window cooling unit. The "round" thermostat has a tamperproof plastic cover that can be painted to harmonize with the interior color scheme of the hospital room. **Minneapolis-Honeywell Regulator Co., 2820 Fourth Ave. S., Minneapolis 8, Minn.**

For more details circle #422 on mailing card.

Cork-Surfaced Trays Reduce Noise

Dishes, glassware and silver will not slip on the new Kys-Ite Cork-Surfaced Tray. Noise of serving and clearing away is greatly reduced and the attractive tray stays new looking even after repeated sterilization in a washing machine. The cork is molded into the plastic, ensuring long hard use and wear. Tests indicate that the cork will not come off and does not show stain, even in hard usage. The new trays are available in red and brown and in three sizes, 11 inch and 14 inch round, and 18 by 14 inches oblong. **Keyes Fibre Sales Corp., 420 Lexington Ave., New York 17.**

For more details circle #423 on mailing card.

Deep-Fat Fryer for Small Loads

The new Chefmaster is a deep-fat fryer for relatively small amounts of foods. It has a capacity for 6½ pounds and is made with a one-piece, heavy cast aluminum kettle, with embedded Calrod units. It heats up to proper cooking temperatures rapidly and has a high rate of temperature recovery when cold foods are added to the fat.

The unit is easily cleaned and requires no training or special skill for proper operation. It has an independent temperature control light, heat resistant handles and knobs, and improved grease drain valve. It is attractively designed and is finished in heavy baked-on enamel. **Bloomfield Industries, Inc., 4546 47th St., Chicago 32.**

For more details circle #424 on mailing card.

Maternity Pads Individually Packaged

Delivered to the hospital ready for sterilization and use, the new Bauer & Black Prepackaged Maternity Pads save hand labor and material normally spent in preparing pads in the hospital. They also provide safe aseptic perineal care. The new No. 659 Kotex are each sealed in an imprinted bag. The rugged paper stock used withstands the heat of repeated autoclaving, maintaining sterility until the package is opened. It also

provides a sanitary disposal bag for the soiled pad. **Bauer & Black, 309 W. Jackson Blvd., Chicago 6.**

For more details circle #425 on mailing card.

Complete Sanitation Offered in Coved Sinks

The new Seco all-coved sinks, die-stamped of 14 gauge stainless steel or galvanized after fabrication, have every outside corner rounded and every inside corner coved for easy and complete cleaning. All bowls are one-piece, seamless, deep-drawn for ease of sanitation and are available in two standard sizes, 15 by 20 or 20 by 22 inches. The sinks are offered in 24 models with integral drainboards and bowls in a number of arrangements. The fluted drainboards are pitched to the sink and bowls are designed for complete drainage, with no pockets. Pipe legs have stainless steel adjustable feet. Every bowl is equipped with a duo-strainer type drain. Electric or gas heater can be furnished in one compartment for sterilizing. **Seco Company, Inc., 5206 S. 38th St., St. Louis 16, Mo.**

For more details circle #426 on mailing card.

(Continued on page 230)

Variety of Needs Filled With Felteen

An all-new 100 per cent cotton product which serves as cast liner and for various nursing aids is offered in Felteen. Felteen resists moisture, is non-toxic and conforms evenly to body contours. For cast liners it is supplied in three yard rolls, one yard in width. It is easily worked and may be cut, torn or peeled to any thickness or shape required. Felteen does not bunch, form pressure rolls or thin out but acts as reenforcing blocks and pads in casts and reduces the use of cotton wadding.

Felteen is also used in a disposable incontinent receptor which facilitates care of incontinents by keeping the patient off the wet area. The design of the filter is such that liquid is absorbed quickly by the bottom third of the material, leaving the top dry for maximum patient comfort. The receptor is made with a highly absorbent filler inside a non-toxic, leakproof, plastic envelope. It is completely disposable. Felteen is also used for the Heel-O-Rest. This is a strong, resilient pad cut and shaped to stay on the patient's heel to prevent bed sores and increase patient comfort. **Varo-Met, 4328 Milwaukee Ave., Chicago 41.**

For more details circle #427 on mailing card.

Food Chopper Offers Dual Service

The new Merry G'Rinder is a multiple use Kitchen appliance. The single no-clamp base with handle stands on four powerful suction cups for firm support. Two interchangeable heads are provided for various kitchen chores. The Saladmaker head is completely equipped with three cones for shredding, vegetable slicing and grading. The Meat and Food Chopper head chops raw or cooked meats, nuts, garnishes, bread crumbs and other foods. It is equipped with a four bladed double edged knife for increased life. A fine plate and a coarse plate are provided for varying needs. The base

and handle are finished in white with all other parts either tinned or plated for long rustproof service. **General Slicing Machine Co., Inc., Walden, N.Y.**

For more details circle #428 on mailing card.

"Fresh up" with Seven-Up!

THE ALL-FAMILY DRINK... so pure,

so good, so wholesome for everyone!

You like it... it likes you!

GET A FAMILY SUPPLY OF 24 BOTTLES. Buy 7-Up by the case. Or get the handy 7-Up FAMILY PACK. Easy-lift center handle, easy to store.

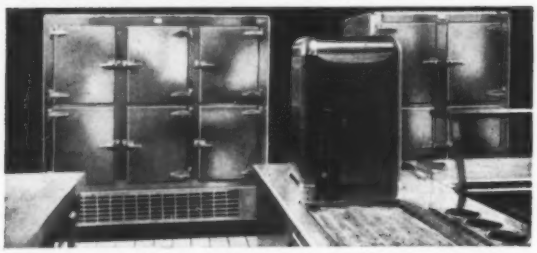
HERRICK

STAINLESS STEEL REFRIGERATORS

Performance-Proved

at *Neiman-Marcus* Dallas, Texas

Left: Exterior view of the Neiman-Marcus downtown specialty store. A recent $7,500,000 expansion program included doubling the space of this store, adding a new $2,000,000 suburban store and a new $1,000,000 service building to serve the two units. DeWitt and Swank of Dallas were the architects for the entire project.



Above: Part of the kitchen which serves the "Zodiac" Restaurant and two employee restaurants in the main store. Shown left to right . . . are HERRICK Models SP60B (6-door) and SP33B 4-door).

Right: A close-up of HERRICK Model SP33B in the Neiman-Marcus kitchen. HERRICK units for this kitchen were supplied by Huey and Philp, Dallas.

From a small, two-story building in 1907, Neiman-Marcus has grown to be one of the largest retail distributors of fine merchandise in the world. Pride of the southwest, this forward-looking organization has always pioneered in progressive merchandising. Neiman-Marcus *sells* the best . . . Neiman-Marcus *buys* the best. That's why they selected HERRICK Stainless Steel Refrigerators for the modern kitchen that services their smart, new "Zodiac" restaurant . . . as well as two employee restaurants. • When HERRICK Stainless Steel Refrigerators are on the job, foods are always kept at peak freshness and flavor. HERRICK'S complete food conditioning provides the ultimate in trouble-free refrigeration. For greater dollar value, buy HERRICK. Write today for the name of your nearest HERRICK supplier.

HERRICK REFRIGERATOR CO., WATERLOO, IOWA
DEPT. M., COMMERCIAL REFRIGERATION DIVISION

HERRICK *The Aristocrat of Refrigerators*

Here's <u>proof</u> that Bassick truck casters last longer

You get more for your money when you buy Bassick truck casters. This photo shows why.

Even a file can't cut the swivel bearing surfaces of these top-quality casters. They're *fully* case-hardened (to 15N90 Rockwell hardness). Special furnaces make sure the right degree of hardness is achieved.

This means you won't be plagued by premature wear or failure of these vital bearing parts when you install Bassick double ball bearing steel casters on service carts, laundry trucks and similar mobile equipment.

Series "99" truck caster

This tough steel caster has fully case-hardened bearing surfaces for longer wear. It's quiet, easy-rolling and easy-swivelling — best bet for institutional trucks. Sizes from 3 in. to 8 in.

Find out more about Bassick casters in the Hospital Purchasing File

THE BASSICK COMPANY, Bridgeport, 2, Conn. *In Canada:* Belleville, Ont.

Bassick

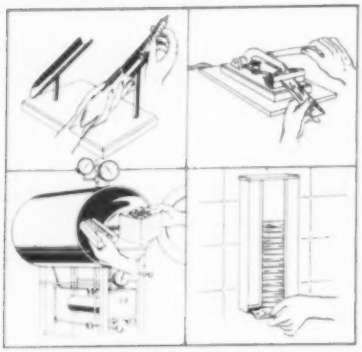
A DIVISION OF STEWART SW WARNER

MAKING MORE KINDS OF CASTERS . . . MAKING CASTERS DO MORE

75 YEARS OF CASTER LEADERSHIP

What's New . . .

Sterility Assured With Steriphane System



A simplified method of handling hypodermic needles and syringes as well as catheters for sterilization and dispensing is offered in the Steriphane System. It is designed to provide assurance of sterility without possibility of contamination. Each syringe and needle is washed and cleaned, ready for sterilization, in the usual manner. It is then loaded into the Steriphane envelope, heat sealed with the Steriphane sealing unit and packed into dispensers. The dispensers are marked to indicate needle or syringe size, placed in the autoclave and sterilized in the usual manner. After sterilization the dispenser full of sterile, wrapped instruments is sent to the nurses' station and wall hung ready for use. Three different sized envelopes are available for syringes. Rubber catheters of any type are handled in a similar manner in preparation for sterilization. After autoclaving they are stored in the Steriphane sealed units until ready for use. **Harold Supply Corp., 100 Fifth Ave., New York 11.**

For more details circle #429 on mailing card.

"Color-Break" Ampules for CRI Germicide

The concentrated rust inhibiting germicide, CRI, is now being offered in a new package. Supplied in "color-break" ampules, the germicide is quickly available by bending and snapping the ampule stem. The neck breaks clean without jagged edges and with no sawing or filing. CRI Germicide is a special formula which, when one 10 ml ampule is diluted, will make a quart of working solution. It is also packaged in pint cans. **Clay-Adams Co., Inc., 141 E. 25th St., New York 10.**

For more details circle #430 on mailing card.

Aluminum Door Can Carry Hospital Name

A new aluminum, narrow stile door recently introduced presents a new idea in push-pull hardware. The push bar is so made that the name, monogram or other design of the hospital may be displayed by simply inserting the special identification plate. A wide selection of attractive stock hardware is available where the identification is not desired.

The new Kawneer door is distinguished by advanced styling with clean, simple lines in keeping with contemporary architecture. The door combines sturdiness with attractive appearance, through aluminum construction, and is designed for the hospital requiring an impressive but economical entrance. The relative light weight of the aluminum construction makes the door easy to operate. A new technic of construction gives the door added strength and rigidity. The door will feature a new dead-bolt lock with tamperproof throw bolts, designed to withstand constant wear under the most adverse conditions. **The Kawneer Company, Niles, Mich.**

For more details circle #431 on mailing card.

Electronic Thermometer Provides Fast Reading

A new clinical thermometer which registers electronically in a matter of seconds and is easily read is available. Known as the Swiftem, it consists of three parts. The small tapered stainless steel tube is applied to the patient in the manner of the conventional thermometer. The tube is plugged into a miniature

socket. A thin, flexible electrical cord is connected to the indicating instrument itself. This is housed in an attractive molded plastic case about the size of a photographic exposure meter. A material in the tip of the tube changes its electrical resistance rapidly with changes in temperature. The instrument is calibrated in degrees Fahrenheit and a push button in the side of the case is pressed when a reading is made.

High accuracy and a speed of 3 to 5 seconds to obtain a reading are features of the Swiftem, which saves time and effort for doctors and nurses. There is no breakage with the Swiftem, it is sterilized in the conventional manner and it has a luminous dial for viewing at night. It can be used effectively for taking rectal temperatures. **Burlington Instrument Co., Burlington, Iowa.**

For more details circle #432 on mailing card.

Light Weight and Durability in Folding Table

The Hostess Featherlight Folding Table is a newly designed unit combining light weight with beauty and durability. It incorporates many modern features including square tubular steel legs uniquely designed to provide knee room at both table ends and to eliminate leg-straddling. Legs are fully braced to withstand hard use and are paired for quick set up, with positive locking catch. The table has a marproof Tauplon top with taupe colored molding. It is available in 30 inch by 6 foot size. **Brewer-Titchener Corporation, Cortland, N.Y.**

For more details circle #433 on mailing card.

Interior Wall Decoration Combines Color and Design

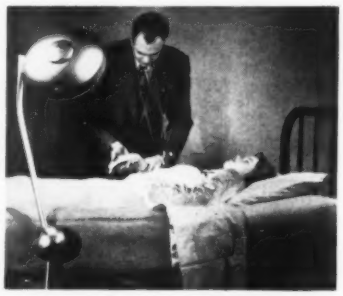
Super Kem-Tone Applikay is a new development in interior decoration. A specially designed twin roller produces an attractive, brocade-like design on painted walls which minimizes smudges and finger marks, making it especially effective for decoration of patients' rooms, corridors, reception rooms, libraries, nurses' homes, cafeterias and other areas. The finish can be readily washed and scrubbed when necessary.

Applikay has an opalescent sheen giving a silk-brocade effect to the finished wall when viewed from various angles. Designs are applied to surfaces first coated with Super Kem-Tone. A fabric covered roller and a plastic roller, on which any of five different designs are embossed, are used for the application. The fabric roller picks up the Applikay from a paint tray and distributes it evenly over the design roller in the process of application. Applikay is available in a variety of attractive colors. **The Sherwin-Williams Co., 101 Prospect Ave., N. W., Cleveland 1, Ohio.**

For more details circle #434 on mailing card.

Rotary Bedside Lamp Serves for Examinations

Five different types of illumination are offered in the new Faries "Rotary" Bedside Lamp. A special "Rotary" reflector which can be easily snapped on the socket gives a spotlight for examinations. Direct or indirect light is provided when the shade is directed toward the patient as well as when it is directed away from the patient. A night light is also incorporated into the fixture. The lamp is so designed that the cord cannot twist or turn, regard-



less of the position of the shade. **Faries Lamp Division, General Lamps Mfg. Corp., Elwood, Ind.**

For more details circle #435 on mailing card.

(Continued on page 234)

For the ultimate in economy, beauty and quality... for your hospital furniture—look to Royal and Englander

metal furniture since '97

Royal

1 COMPLETE SERVICE
FROM 2 GREAT NAMES

Englander
SLEEP PRODUCTS

Illustrated is the Royal Bedside Cabinet which has reversible door that can be changed to open from either left or right. It has bonderized Plastelle baked-enamel finish on zinc plated steel . . . double wall construction on drawer and door . . . pedestal island base with adjustable floor guides . . . 1¼" removable and replaceable self-banded Formica top or one-piece metal which prevents dirt accumulation in crevices.

Royal, the top quality manufacturer of metal furniture since '97 . . . and Englander, the acknowledged leader in quality sleep products, now, together offer you one complete line of hospital furniture, available through either company. See your Royal or Englander dealer today!

Royal Metal Manufacturing Co., 175 N. Michigan Ave., Chicago 1, Ill. • The Englander Co., Inc., Contract Dept., 1720 Merchandise Mart, Chicago 54, Ill.

Let **HOFFMAN'S** *comprehensive experience*

be **YOUR GUIDE** *in laundry planning and service*

The world's most extensive and most advanced knowledge of institutional laundries, covering all phases of their design, equipment and operation, can be your assurance of providing the very best in laundry facilities.

Whether you are considering a new laundry installation, or are concerned with modernizing present facilities for greater capacity and effectiveness, Hoffman's 3-fold service for planning, equipping and operating is your surest way to low linen processing cost per patient day.

Write for your copy of the booklet describing Hoffman institutional laundry equipment service.

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MACHINERY CORPORATION
105 FOURTH AVENUE, NEW YORK 3, N. Y.

What's New . . .

Patient Room Furniture Designed by Loewy

Raymond Loewy Associates have designed a new line of hospital furniture brought out by Hill-Rom. Howard Ketcham, color engineer, is responsible for color styling in the new line. Modern design, engineering and color styling are combined with hospital-proven efficiency and quality in the five complete new room groupings available. Each of the groupings includes new designs in beds, bedside units, dressers, overbed tables, easy chairs and straight chairs. The beds are all equipped with the No. 25 Trendelenburg two-crank spring and are available in either standard type or crank operated or motor driven Hi-low models.

The basic groupings combine functional serviceability, versatility and styling. Selected woods, wood finishes, metal finishes and hardware are used in conjunction with restful color accents. The grouping pictured is of natural finish quartered walnut. All metal parts for the case goods, including removable tray type drawers, are stainless steel, satin finished. Satin stainless leg ferrules are incorporated in the metal-wood bed design. The head and foot boards are trimmed with a protective satin finish aluminum extrusion. All top surfaces in the all-wood grouping are protected with high pressure laminate. **Hill-Rom Co., Inc., Batesville, Ind.**

For more details circle #436 on mailing card.

Heavy Duty Equipment Cleans at Low Cost

The new Premier Model 908G heavy duty floor cleaner meets normal maintenance requirements at low cost. It is designed to permit quick conversion of the motor unit to a powerful blower by removal of the filter bag and substitution of a blower coupling and guard. The machine has a one h.p. motor and a container capacity of 1.04 bushels of dry dirt or 10 gallons of liquid for wet pickup. It is made of heavy sheet steel, finished in metallic gray. Soft rubber tread casters with top swivel bearings make it easy to move the cleaner to points of need. A standard set of cleaning tools is furnished with the heavy duty cleaner. **Premier Co., 755 Woodlawn Ave., St. Paul 1, Minn.**

For more details circle #437 on mailing card.

Apparatus for Injection in Perirenal Insufflation

The injection of oxygen, carbon dioxide or other gas in the procedure of perirenal insufflation can be efficiently handled with the new Ritter Pneumoroentgenography apparatus. Consisting of a metal support for mounting a glass cylinder and a three-way valve, the apparatus permits a measured quantity of oxygen or other gas to be passed into the glass cylinder without entering the gas to patient circuit. When the cylinder is filled with the required quantity, the valve is reversed and the flow carried directly to the injection tube and needle. A connection in this circuit permits observation of the pressure during injection. If a permanent record is desired, the device can be connected to a Lewis Systometer. **American Cystoscope Makers, Inc., 1241 Lafayette Ave., New York 59.**

For more details circle #438 on mailing card.

Folding Screen of Aluminum

An aluminum frame and aluminum textured panels, anodized in satin finish for lifetime use, are combined in the new Life-Time Folding Screen. The panels are permanently fastened into the tubing and need never be replaced. They can be easily kept clean and the screen is light in weight and easily moved.

The screen is available in three models, that with aluminum textured panels illustrated, one with colored vinyl panels with rods top and bottom for quick panel change and a precision formed base permitting greater width adjustment and stability, and one with colored vinyl panels and a glide base. All frames are of heavy ¾ inch tubing with stainless steel hinges. **Beam Metal Specialties, 25-11 49th St., Long Island City 3, N.Y.**

For more details circle #439 on mailing card.

Laundrite Washer for Special Work

A small open end type washer is now available for the laundry in the smaller hospital or for processing special work in the large hospital laundry. The Troy Laundrite Washer has a capacity of 25 pounds and is available with both automatic and semi-automatic features. It is constructed on the heavy duty lines used in larger washers with stainless steel in the cylinder and shell and quiet "V" belt drive. The Laundrite is compact and easy to operate. **Troy Laundry Machinery Div., American Machine and Metals, Inc., East Moline, Ill.**

For more details circle #440 on mailing card.

Improved Electric Broiler in Five Combinations

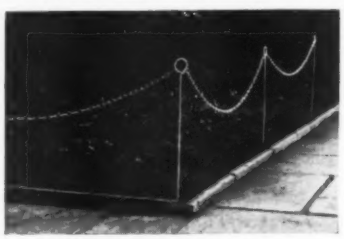
The new improved Hotpoint electric broiler is said to offer fast four section Calrod broiling units, fast pre-heating performance, high production capacity and a pistol grip which remains cool to the touch. Power of the new units has been stepped-up to lower the preheating period considerably. Heat can be measured as an exact ingredient in the precision machine, holding selected temperatures for year after year of heavy-duty use, ensuring uniform results for the long life of the device. The improved broiler is available in single or double broiler with oven or cabinet base, and single broiler without base. **Hotpoint Co., 227 S. Seeley Ave., Chicago 12.**

For more details circle #441 on mailing card.

Decorative Chain Fence for Lawns and Drives

Made of heavy 1½ inch chain links and tubular steel stakes, the Ship's chain fence is finished in white baked enamel. It provides a decorative fence for lawns, drives or walks, protects plantings and grass, outlines parking areas, and provides a decorative trim to walks and drives.

The new fence is offered in "pre-fab" packages containing four 6 foot sections of chain, five 3 foot seamless tubular steel stakes, and 8 S-hooks to attach chain to stake loops. It can be erected quickly and easily by simply driving the stakes into the ground to the desired depth. A decorative scalloped effect is obtained by locating the stakes at intervals less than six feet. The fence does not interfere with grass cutting or trimming as mowers can be run under it. The fence can be



opened at any stake, for moving implements by raising one of the S-hooks. **The Warren Products Company, 1836 Euclid Ave., Cleveland 15, Ohio.**

For more details circle #442 on mailing card.

(Continued on page 238)

SO SATISFACTORY was the performance of 2 National Class 31 Accounting Machines at the Lenox Hill Hospital, a third is now on order.

BOTH PATIENT AND HOSPITAL benefit from National's speed and efficiency at the Lenox Hill Hospital.

"Our *National* Accounting Machines will pay for themselves many times over in the next few years!"

—Lenox Hill Hospital, New York, N. Y.

"Lenox Hill is a large hospital," writes Mr. Charles W. Bush, Comptroller, "with 511 beds and 68 bassinets. So you can appreciate the volume of accounting we must handle day in and day out.

"That's why we are highly pleased with the performance of our two National Class 31 Accounting Machines. They service, with speed and efficiency, our Accounts Receivable or patients' billing, Accounts Payable, Expense Distribution, Payroll, W-2 and 941-Quarterly reports. We post our patients' bills at night with these machines and, therefore, bills are always ready for re-use or payment the following morning.

"We also use three National Cash Registers in our 'Inside Inn,' gift shop and cafeteria.

"We have an additional Class 31 on order. This National will be used for Income Distribution, General Ledger, Cash Receipts and Expense or Budget Comparison.

"From the time and money our Nationals save, we know they will pay for themselves many times over in the next few years!"

Hospitals of every type and size report substantial savings from Nationals. They soon pay back their cost, and continue returning a handsome *extra* profit every year. For full details on a National System to meet the needs of *your* hospital, call your nearby National representative, a trained systems analyst. He's listed in the yellow pages of your phone book.

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National

ACCOUNTING MACHINES
ADDING MACHINES • CASH REGISTERS

THE NATIONAL CASH REGISTER COMPANY, DAYTON 9, OHIO

949 OFFICES IN 94 COUNTRIES

How to do more work without adding employees

A simple rinsing with warm water quickly cleans this stainless steel food conveyer. More easy-to-clean ENDURO hospital equipment includes kitchen equipment, instruments and instrument cabinets, sterilizers, autoclaves, operating room fixtures, kick plates and trim, utensils, piping and tubing.

Cut clean-up time and you free hospital help for more productive duties. Lighten your housekeeping and you stretch your operating budget. And you can do this where you use equipment made of Enduro Stainless Steel.

Take cleaning. Usually a quick rinse and a wipe will do the job. Or a simple washing with soap and water. And unskilled help can do it. Very seldom does Enduro equipment need hard scrubbing that takes valuable time.

Take durability. Enduro stubbornly resists rust and corrosion. It resists the bumps, dents and abrasion of daily use. And it has no surface covering to chip, peel, crack or wear away.

With budgets tight and help hard to find, now is the time to invest in long-lasting Enduro Stainless Steel equipment. Ask your equipment supplier to give you the facts. Or write to:

REPUBLIC STEEL CORPORATION
Alloy Steel Division • Massillon, Ohio
GENERAL OFFICES • CLEVELAND 1, OHIO
Export Department: Chrysler Building, New York 17, New York

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REPUBLIC STEEL

Other Republic Products include Carbon and Alloy Steels — Steel and Plastic Pipe, Tubing, Lockers, Shelving, Fabricated Steel Building Products

What's New . . .

Tomac Anniversary Suite Has Custom Construction

Custom cabinet construction with permanently fitted mortise-and tenon or double dowel workmanship is used in all pieces of the Tomac Anniversary Suite which was developed for patients' rooms. It was created by Roy Johnson, A.I.D., and manufactured by Tomlinson from solid and laminated black cherry with the natural luster enhanced by the Tomlinson "Durabake" process. The finish was tested by the U.S. Bureau of Standards and showed no damage under varying tests, according to the manufacturer. Matching Micarta is used at wear points and on all top surfaces. A wide choice of upholstery in nylon, Naugahyde and Madagaska is available for items in the suite. **American Hospital Supply Corp., Evanston, Ill.**

For more details circle #443 on mailing card.

Aspirating Syringe Has Permanent Tip

The Aspirating Tip is permanently seal-fitted to the Vim Gabriel Aspirating Syringe. It is designed to provide complete and positive aspiration with maximum ease. Withdrawal of solutions from vials is simplified and contamination and waste of medication are eliminated with the new unit.

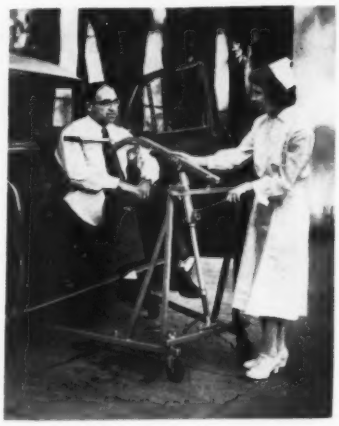
The large gauge, short, sturdy Aspirating Tip easily penetrates even the toughest diaphragm type vial stoppers, permitting easy withdrawal of even the most viscous solution. The injecting needle locks smoothly on to the syringe over the aspirating tip, never touching the vial. Needle life is thus increased and the needle is used only for injection. **MacGregor Instrument Co., Needham, Mass.**

For more details circle #444 on mailing card.

Patient Lift Is Easily Operated

Even the heaviest patient can be lifted without effort in the Lifteez Invalid Lift. A hydraulic pump permits raising or lowering at a gentle rate of speed without jarring or discomfort. Patients are easily and comfortably lifted in and out of bed or wheelchair and can be easily transferred into an automobile. The patient can operate the lift without the aid of a nurse if desired. Lifteez can also be used as a walker after surgery or long illness.

The Lifteez has a safety "Seat-Back" which is easily adjusted and permits the patient to relax without anxiety while being transported. Lifteez is mounted on hard rubber casters for easy moving and can be narrowed for passage through



narrow doors. A head support is available where needed. **Lifteez Company, 942 S. La Brea Ave., Los Angeles 36, Calif.**

For more details circle #445 on mailing card.

(Continued on page 242)

"The Roosevelt Hospital gets maximum value from everything they buy",

says Wallace O. Banker

Mr. Wallace O. Banker, Purchasing Agent,
The Roosevelt Hospital, New York, N. Y.

Mr. Banker writes, *"With today's costs so important a factor in the operation of hospitals, we here at The Roosevelt Hospital must get maximum value from everything we buy. That's why we use the Utica Muslin sheets and pillowcases as a standard. Replacement costs are at a minimum, and their smooth texture aids the patient's comfort."*

A wise hospital purchasing agent buys value. Sheets and pillowcases must be comfortable and wear well throughout their long life. That's why so many experienced buyers of hospital supplies select Utica Muslin Sheets, woven with over 140 threads to the square inch (finished count). They are made of carefully selected cotton, in one of the most modern mills of its kind in the world. Utica Muslin Sheets fulfill your rigid requirements of high quality and long service at low cost.

Wherever America sleeps . . . . . .

Stevens UTICA-MOHAWK Sheets

SHEETS AND PILLOW CASES · STEVENS · UTICA MOHAWK · TRADE MARK

J. P. STEVENS & CO., INC., STEVENS BUILDING, BROADWAY AT 41st ST., N. Y. 36, N. Y.

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For complete details, contact your own contractor, or write J. P. Stevens & Co., Inc., for the name of the contract distributor nearest you.

What's New . . .

Wound Preparation Expedited With Prep Tray

The scrubbing and cleansing of traumatic wounds is eased by use of the new stainless steel Extremity Prep Tray. It provides a convenient and effective receptacle beneath the extremity where the scrubbing and wound flushing take place, thus expediting the preparations for orthopedic surgery. All soap, saline or water is trapped and carried to a sink or jar by a rubber tube attached to the drain spout. The perforated cover is removable for cleaning and sterilizing. The new Prep Tray is 21 inches long and 13 inches wide. **Ille Electric Corp., 50 Mill Road, Freeport, L.I., N.Y.**

For more details circle #446 on mailing card.

Stria Acoustical Tile Is Non-Combustible

Many distinctive decorative possibilities in ceiling design can be achieved with the new non-combustible Stria Acoustical Tile. The new tile, while low in cost, has exceptionally high acoustical values and presents multiple striations or grooves. The tile surface has a pleasing appearance which blends with modern or traditional interiors. It reflects more than 75 per cent of light.

Stria Acoustical Tile is a Fiberglas sound control product which is dimensionally stable, fire safe, will not rot, absorb or give off odors, and offers no sustenance to bacteria, termites or vermin. It does not warp, buckle, expand or contract under varying conditions and is easily cleaned with fresh wall paper cleaner or by the vacuum method. It is available in 12 by 12 and 12 by 24 inch sizes and may be spray painted with non-bridging water-base paint without affecting its noise reduction efficiency. **Owens-Corning Fiberglas Corp., Toledo 1, Ohio.**

For more details circle #447 on mailing card.

Safety Sides for Every Bed Type

Clamping to the spring rail without tools, the new H31-A Safety Sides are easily raised and lowered with one hand operation. They can remain on the bed under any circumstances for ready availability when needed and fit Trendelenburg beds, standard Gatch beds, and multiple height beds. They do not touch the floor even when the bed is in lowered position. The protective height of the side above the mattress remains constant, regardless of spring height.

The use of one type of side with all types of beds permits standardization, minimizing storage problems. The sides do not interfere with bedside cabinets

or other furniture as they are raised or lowered by a simple, effortless sliding movement. **Inland Bed Co., 3921 S. Michigan Ave., Chicago 15.**

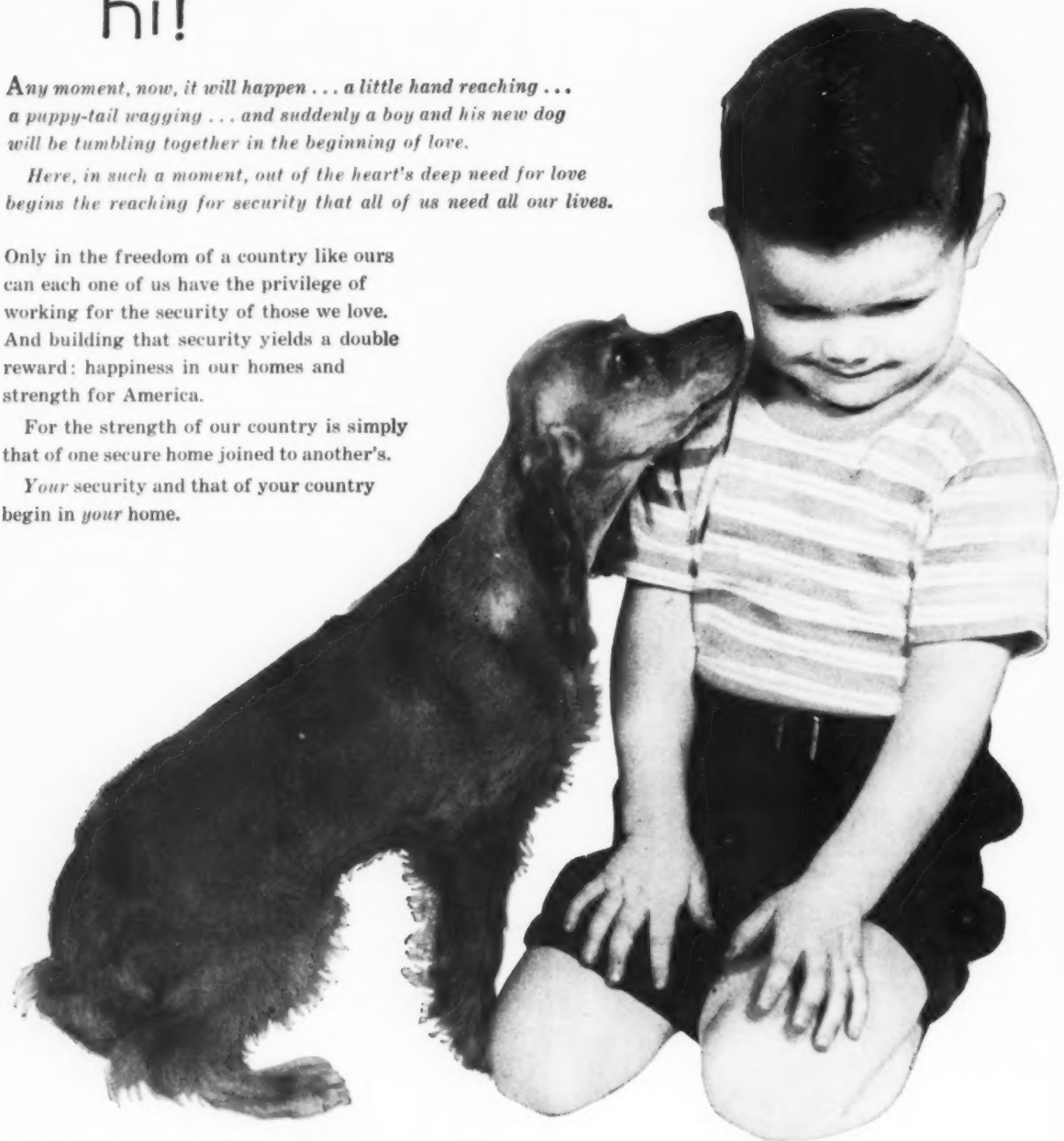
For more details circle #448 on mailing card.

(Continued on page 246)

hi!

Any moment, now, it will happen . . . a little hand reaching . . . a puppy-tail wagging . . . and suddenly a boy and his new dog will be tumbling together in the beginning of love.

Here, in such a moment, out of the heart's deep need for love begins the reaching for security that all of us need all our lives.



Only in the freedom of a country like ours can each one of us have the privilege of working for the security of those we love. And building that security yields a double reward: happiness in our homes and strength for America.

For the strength of our country is simply that of one secure home joined to another's.

Your security and that of your country begin in *your* home.

Saving for security is easy! Read every word—now!

If you've tried to save and failed, chances are it was because you didn't have a *plan*. Well, here's a savings system that really works—the Payroll Savings Plan for investing in U.S. Savings Bonds. This is all you do. Go to your company's pay office, choose the amount you want to save—a couple of dollars a payday, or as much as you wish. That money will be set aside for you before you even draw your pay. And automatically invested in Series "E" U.S. Savings Bonds which are turned over to you.

If you can save only $3.75 a week on the Plan, in 9 years and 8 months you will have $2,137.30.

United States Series "E" Savings Bonds earn interest at an average of 3% per year, compounded semiannually, when held to maturity! And they can go on earning interest for as long as 19 years and 8 months if you wish, giving you a return of 80% on your original investment!

Eight million working men and women are building their security with the Payroll Savings Plan. For your sake, and your family's, too, how about signing up today? If you are self-employed, ask your banker about the Bond-A-Month Plan.

The U.S. Government does not pay for this advertisement. It is donated by this publication in cooperation with the Advertising Council and the Magazine Publishers of America.

What's New . . .

Haematype Cards Speed Blood Typing

No preparation or complicated procedures are necessary for determining blood grouping and Rh typing with the new Haematype Cards. This fast new blood typing procedure has consistently proved accurate in tests conducted in hospital laboratories and blood banks throughout the country. The Haematype Card is coated with Dade Serums, permitting typing right on the card itself. Reactions are quick and when the card dries, in approximately ten minutes, it becomes a permanent record for the hospital or the patient. **Scientific Products Division, American Hospital Supply Corp., Evanston Ill.**

For more details circle #449 on mailing card.

Glazed Wall Tile Now Offered in Large Size

A new large sized glazed wall tile is now being made available. The 9 by 6 by ½ inch sized tiles are of smooth glazed Mosaic Clay Tile requiring lowest-cost substructure and providing permanent beauty, sanitation and easy maintenance. The tile is especially suited for walls in kitchens, cafeterias, laboratories, corridors, operating suites, lobbies and other areas which must be kept clean and sanitary and withstand hard wear.

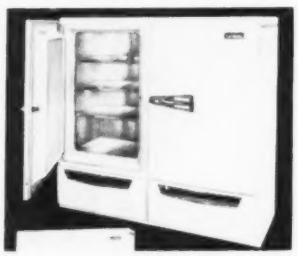
Large sized Mosaic Glazed Wall Tile can be installed by either conventional or thin-setting bed methods, requires no expensive special trim shapes, and has integral spacers for uniform close joints. It is available in the full range of Mosaic Harmonitone-Matt and Bright Glaze colors. In combination with Mosaic Impervious Electrically-Conductive Ceramic Mosaic Floor Tile it is especially suited for operating room use. It can also be combined with other Mosaic Clay Tile for hospital installations for durability and ease of maintenance. **The Mosaic Tile Company, Zanesville, Ohio.**

For more details circle #450 on mailing card.

Freezer-Refrigerator Combination in Upright Model

The Model 20/20 appliance brought out by Jordon Refrigerator Company is a dual-temperature unit. The left half is a freezer and the right half has normal refrigeration temperatures. It is an upright model designed for institutional and commercial use and providing all refrigeration needs in one unit. Each half of the refrigerator-freezer combination has its own controls and its own dry storage bin at the bottom. It is a compact unit designed to fit into most institutional kitchens.

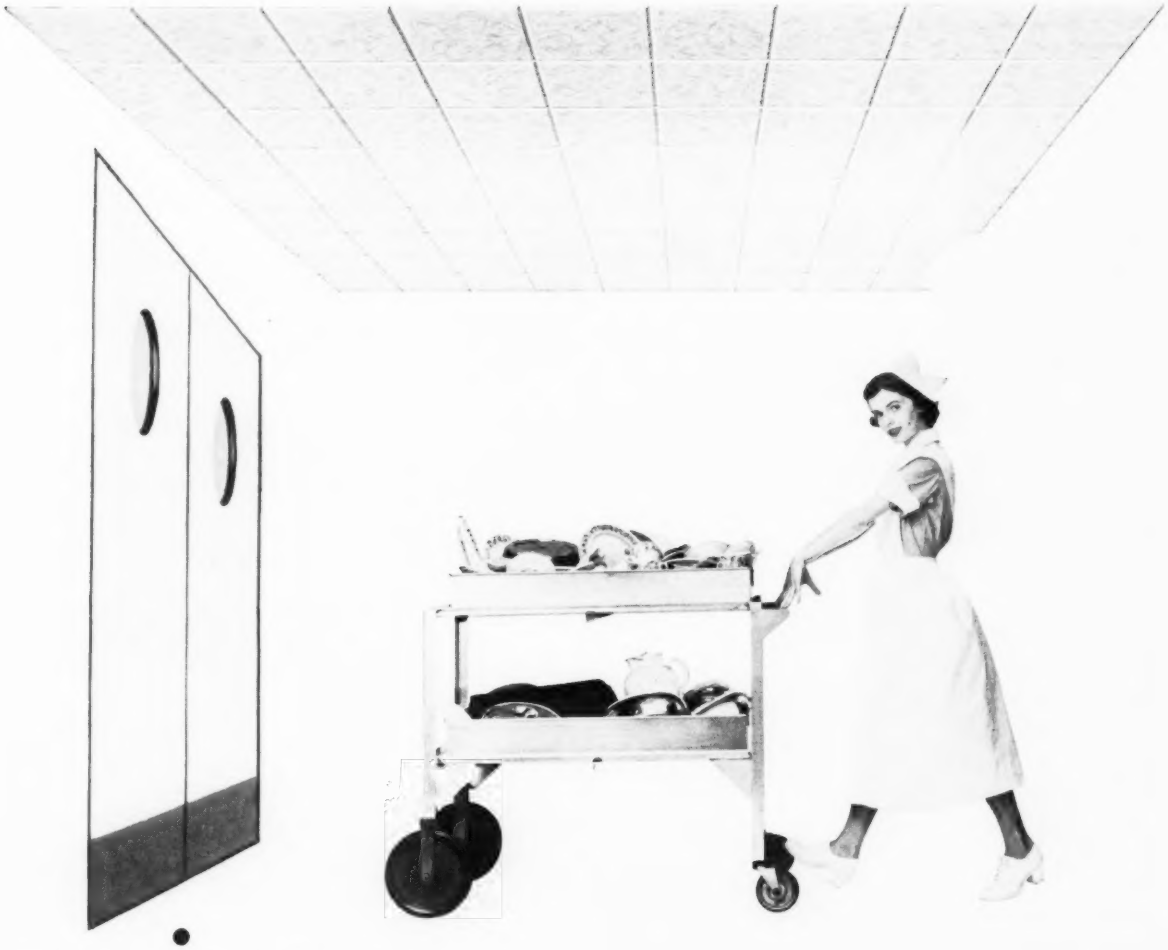
The refrigerator section features the Jord-O-Matic cooling system for scientific air control, automatic defrosting and minimum loss of cool air when the door is opened. Ease of maintenance is ensured through the use of anodized aluminum interiors in both halves of the unit. Shelves in the refrigerator section are adjustable and the freezer portion has Jordon freeze plate shelves for rapid



freezing. The cabinet is of all welded steel construction with white baked enamel finish. **Jordon Refrigerator Co., 7900 Tabor Rd., Philadelphia 11, Pa.**

For more details circle #451 on mailing card.

(Continued on page 248)



quiet... plus supreme fire-safety

with **Fiberglas Acoustical Ceilings**

You want your hospital to be quiet . . . for increased staff efficiency and patient comfort. But you don't want to compromise with fire-safety.

Then choose ceilings of Fiberglas* Sound Control Products for both quiet *and* fire-safety. These ceilings absorb up to 75% of all noise and give you other important advantages besides!

SAFE—Fiberglas Sound Control Products satisfy the strictest building code requirements. They are rated non-combustible under Federal Specification SSA-118a and by the Acoustical Materials Association, and carry the Underwriters' Laboratories label service.

PERMANENT—Fiberglas Sound Control Products are beautifully permanent . . . permanently beautiful. They can't rot, absorb odors, furnish nourishment to termites or fungi. Won't warp, shrink or swell. And they provide added thermal insulation at no added cost.

LOW COST—In fact, the *lowest* cost fire-safe ceilings. Fiberglas Sound Control Products are installed easily, and so provide no major interruption to your normal routine.

Our informative new booklet, "The Medicinal Ceiling," is bound to be of interest to you. Write for your free copy now.

*Fiberglas (Reg. U. S. Pat. Off.) Sonofaced, Stria, and Noise-Stop are trade-marks of Owens-Corning Fiberglas Corporation.

OWENS-CORNING
FIBERGLAS
SOUND CONTROL PRODUCTS
- Textured, Perforated, Sonofaced*, Stria* Acoustical Tile
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Owens-Corning Fiberglas Corporation
Dept. 141-I, Toledo 1, Ohio

Please send me a free copy of your new booklet, "The Medicinal Ceiling."

Name.....

Position.....

Company.....

Street.....

City.....**Zone**.....**State**.....

What's New . . .

Combination Diagnostic X-Ray in Kelescope Unit

Simplified push button operation is offered in the full sized combination radiography and fluoroscopy diagnostic Kelescope. Minimum floor space is required for the 100 MA at 100 KV full wave rectified unit. It offers complete diagnostic x-ray service with simplified technic. The table can be positioned as desired from horizontal to Trendelenburg to vertical. It is available as a single tube or a two tube unit incorporating a separate shockproof tubehead for fluoroscopy.

Protection from stray radiation is provided in the unit which affords great energy output with low power consumption. The rugged basic construction ensures years of trouble-free operation. **Keleket X-Ray Corporation, 212 W. Fourth St., Covington, Ky.**

For more details circle #452 on mailing card.

Soluble Coffee for Quantity Brewing

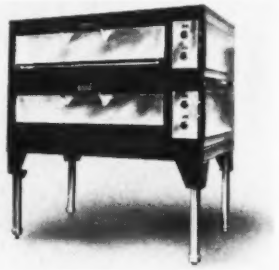
Instant Maxwell House Coffee is now available in special packages for quantity brewing. This new type of instant coffee is offered in two convenient pre-measured quantity packs, one for urns and one for glass coffee makers, both scaled on a pound-equivalent basis. The packs are aluminum foil, lined with polyethylene to keep the product fresh and moisture-proof indefinitely. Brewing time for 2½ gallons of Instant Maxwell House Coffee is under three minutes and coffee can be made wherever there is hot water, even by untrained personnel. **General Foods Corporation, Maxwell House Division, Hoboken, N.J.**

For more details circle #453 on mailing card.

Baking and Roasting Oven Employs New Principle

The newly developed Trubake-Southbend Baking and Roasting Ovens are being manufactured by the Malleable Steel Range Manufacturing Corporation of South Bend, Indiana. A new principle of design, employing independently and accurately controlled top and bottom heat, permits controlled baking and roasting. The result can be a roast as rare at the ends as in the center, or as well done in the middle as at the ends. The new oven is easily operated by means of two dials. The aluminum alloy hearth heats evenly, with rapidity.

The construction of the oven is such that the top is cool enough to be used as a desk or table even with inside temperatures at 400 or 500 degrees F. Marinite, a structurally strong, heat resistant, non-metallic insulating material, is used in the construction of the oven. It eliminates through-metal conduction to help produce the cool exterior. **Trubake Gas Oven Co., Inc., 162 E. 37th St., New York 16.**



For more details circle #454 on mailing card.

(Continued on page 250)

What's New . . .

Microfilming Equipment in Low Cost, Compact Unit

The Micro-Twin is a new low-cost microfilming machine which combines recording and reading in one unit. The compact machine is designed for table top operation, occupies 23 by 32 inches of space and is 13½ inches high. It has a rugged, light weight aluminum channel frame covered with plywood and the machine can be carried easily by two persons. The working surface of melamine plastic resists stains and burns.

Controls have been simplified in the Micro-Twin which can be operated by any personnel with only a few minutes of instruction. It will record a wide range of material, from documents smaller than bank checks up to single sheets 11 inches wide and 3700 feet long, photographing both sides. Documents intermixed in size can be photographed in rapid succession. The screen for viewing microfilmed material is 8 by 11 inches in size. The same machine can be used to reproduce copies of any material already microfilmed, without the facilities of a dark room.

As documents are photographed the film is automatically indexed to set up a filing system for quick location of material on the reader. A 100 foot roll of 16 mm film will record the average contents of a four-drawer filing cabinet. Visible, automatic and audible safeguards on the control panel ensure accurate operation. The Micro-Twin is manufactured by **Bell & Howell** and sold by **Burroughs Corp., Detroit 32, Mich.**

For more details circle #455 on mailing card.

Floor Space Saved With Receding Closet Doors

Emco receding closet doors are open and recede into the closet practically the full width. As a result there is no loss of wall or floor space when the door is open, permitting furniture to be placed without concern for door opening. Adequate space is allowed for hanging clothes and there is a shelf above the hangers. The closet is vented for circulation of air and can be cleaned with ordinary cleaning equipment.

The Model 401 Spacemaster is a single room closet with door installed to arc either to the left or to the right, in any desired width. The Spacemaster Twin, Model 402, is designed for double room or ward installation. **Equipment Manufacturing Co., Inc., 1400 Spruce St., Kansas City 27, Mo.**

For more details circle #456 on mailing card.

Seating Space Increased With Half Round Table

A new folding table has been introduced in a half round shape. It was designed to provide increased seating capacity in minimum space and with comfort. The table has a ¾ inch hot lacquered fir top, is 29½ inches high and has a diameter of 60 inches. The Du

Honey 20 Lock automatically locks the legs into regid position for strength and stability. **Midwest Folding Products, Roselle, Ill.**

For more details circle #457 on mailing card.

(Continued on page 252)

What's New . . .

Pharmaceuticals

Infiltrase

Infiltrase is a highly purified hyaluronidase supplied as a lyophilized powder in 1 cc. and 10 cc. vials. It is designed to facilitate subcutaneous administration of fluids, to permit rapid infiltration of local anesthetics and to enhance the action of the pudendal block. It is credited, according to the manufacturer, with preventing new stone formation in renal litiasis, and preventing an increase in the size of existing stones. **The Armour Laboratories, 520 N. Michigan Ave., Chicago 11.**

For more details circle #458 on mailing card.

Erythrocin

Two new forms of Erythrocin have been announced by Abbott Laboratories. Erythrocin Lactobionate is a new soluble salt of Erythrocin for intravenous or intramuscular injection in the treatment of patients who cannot take oral medication or in whom immediate high Erythrocin blood levels are important. It is supplied as a sterile lyophilized powder in 30 cc. vials and in 10 cc. vials.

Erythrocin 1% Ointment is recommended for topical use against stubborn staphylococcic and streptococcic infections of the skin. It is supplied in one ounce tubes. **Abbott Laboratories, North Chicago, Ill.**

For more details circle #459 on mailing card.

Cutter Electrolytes

Cutter Electrolytes Nos. 1, 2 and 3 are three new multiple electrolyte solutions supplementing Polysal. They are designed for use in providing electrolytes for specific therapy and are not patterned after the electrolyte composition of plasma. All three new solutions contain invert sugar 10 per cent, and may be administered either intravenously or subcutaneously. With Cutter Electrolyte No. 1 the lactate and sodium have an alkalizing action. Cutter Electrolyte No. 2 is indicated as a routine maintenance solution for patients with essentially normal kidney function. Cutter Electrolyte No. 3 is intended for replacement of fluid lost through gastric suction or vomiting. **Cutter Laboratories, Berkeley 10, Calif.**

For more details circle #460 on mailing card.

Sterile Solution Cortef

Sterile Solution Cortef is a stable form of hydrocortisone in solution, suitable for injection directly into the vein in cases of severe injury, infection or adrenal failure. It provides adrenal cortical hormones in solution in sufficient concentration to permit intravenous administration in the large dosages often indicated for emergency procedures. **Upjohn Company, Kalamazoo, Mich.**

For more details circle #461 on mailing card.

New Forms of Achromycin

Three new forms of Achromycin have recently been released. Achromycin Hydrochloride Tetracycline HCl Crystalline Ointment contains 3 per cent of tetracycline hydrochloride in a petrolatum-wood fat base. It is for topical application in the treatment of superficial infections of the skin and the prevention of infection in wounds, abrasions and after surgery. Soluble tablets of Achromycin are now available for oral administration. Each tablet contains 50 mg. of tetracycline HCl and may be dissolved in bland or flavored liquids.

Achromycin Intramuscular is a broad spectrum antibiotic, effective against a wide range of gram-positive and gram-negative organisms. It offers high solubility, rapid diffusion into body tissues and fluids, rapid therapeutic action via the intramuscular route and rare occurrence of side effects. **Lederle Laboratories Division, American Cyanamid Company, Pearl River, N.Y.**

For more details circle #462 on mailing card.

Cortril Topical With Terramycin

Cortril Topical Ointment with Terramycin is an ointment containing 10 mg. Cortril and 30 mg. Terramycin per gram. Hydrocortisone has been found effective in local application against inflammatory and allergic skin conditions. The wide-range antibiotic, Terramycin, acts on infections often complicating skin diseases. The combination is indicated for topical application in the control of skin infections and inflammation and is sold in half ounce tubes. **Pfizer Laboratories, 630 Flushing Ave., Brooklyn 6, N.Y.**

For more details circle #463 on mailing card.

Anti-Stress Formula

A S F (Anti-Stress Formula) is a multi-vitamin capsule for the prevention of rapid water-soluble vitamin depletion and the treatment of severe depletion of water-soluble vitamins. The formula follows that recommended by the Food and Nutrition Board of the National Research Council for the treatment of patients seriously debilitated by severe illness, surgical operation or shock. The capsules are supplied in bottles of 30 and 100. **J. B. Roerig & Company, 536 Lake Shore Drive, Chicago 11.**

For more details circle #464 on mailing card.

Clusintrin

Clusintrin is a new preparation providing U.S.P. standardized B_{12} with intrinsic factor concentrate, additional B_{12}, iron and a full complement of hemopoietic elements, for the treatment of anemias. It is supplied in capsule form in bottles of 100 and 1000. **Ayerst Laboratories, 22 E. 40th St., New York 16.**

For more details circle #465 on mailing card.

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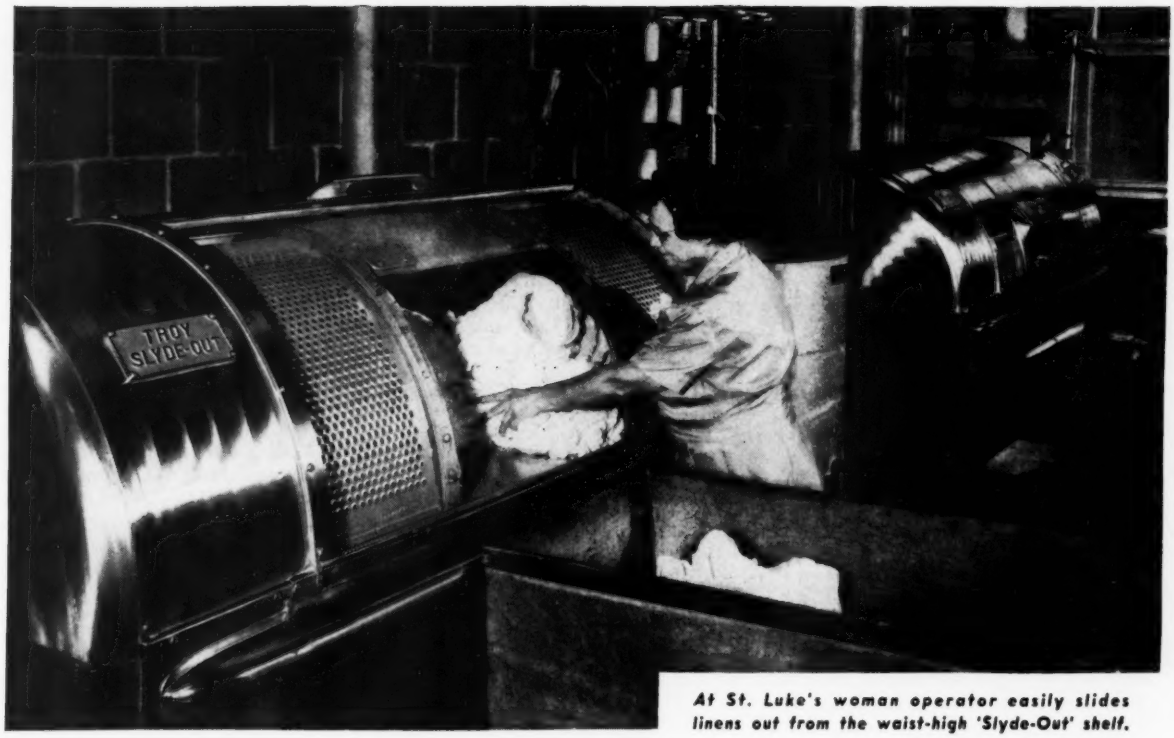

At St. Luke's woman operator easily slides linens out from the waist-high 'Slyde-Out' shelf.

AT ST. LUKE'S HOSPITAL, DAVENPORT, IOWA

LAUNDRY DOUBLES CAPACITY... CUTS COST 18%

WITH ALL-GIRL CREW

"When St. Luke's began plans to increase capacity from 93 beds to 143 beds, and ultimately 200 beds, I realized that our old laundry plant couldn't handle the load," writes Mr. L. A. Bondi, Administrator.

"I told the people at Troy Laundry Machinery about our requirements, and they recommended equipment and proper layout for maximum efficiency. Now our modernized laundry has been in operation for two years. We can turn out twice as much clean linen as previously. We have increased laundry employees' salaries, yet our operating costs are 18½% less than before."

St. Luke's Hospital laundry is equipped with easy-unloading Troy 'Slyde-Out' Washers, Troy extractors, drying tumblers, flatwork ironer and presses. The laundry is staffed entirely by women.

Why not see if Troy planning and equipment can increase capacity and cut costs for you? To get the facts, use the coupon . . . today.

TROY LAUNDRY MACHINERY, Dept. MH-954
Division of American Machine and Metals, Inc.
East Moline, Illinois

☐ Please send me a free catalog on _____
(type of laundry equipment)

☐ Have a Troy representative call on me.

NAME OF HOSPITAL _____

ADDRESS _____

CITY _____ ZONE _____ STATE _____

NAME AND TITLE _____

Troy LAUNDRY MACHINERY
Division of American Machine and Metals, Inc.
EAST MOLINE, ILLINOIS

World's Oldest Builders of Power Laundry Equipment

What's New . . .

Product Literature

Several ideas for **sandwich filling** are offered on a new recipe card by Continental Coffee Co., 375 W. Ontario St., Chicago 90. The new recipes have been developed by Constance Canover, Quantity Recipes Director for that company.

For more details circle #466 on mailing card.

• A new booklet entitled, **"Our Business Is Being Useful,"** has just been published by the Frigidaire Div. of General Motors Corp., Dayton, Ohio. The text outlines the company's essential role in conditioning air, water and food, and it contains illustrations of its commercial refrigeration and air conditioning products and various applications and uses.

For more details circle #467 on mailing card.

• The 15th edition of the **Picker Accessories Catalog** is now available through Picker X-Ray Corp., 25 S. Broadway White Plains, N.Y. The new edition is offered as a reference book for purchasing agents, hospital administrators, radiologists, x-ray technicians and all other persons interested in x-ray work.

For more details circle #468 on mailing card.

• A new catalog, **"New Ideas on Panel-Wall Window Arrangements,"** is available from The William Bayley Co., 1200 Warder St., Springfield 99, Ohio. The text discusses the use of panel-wall construction in a standard set up and gives full descriptive information on Bayley aluminum projected windows and projected ribbon windows. Drawings illustrate details of construction and there are specifications and charts as well as two pages of layouts showing all glass sizes.

For more details circle #469 on mailing card.

The **"Elgin Exercise Unit Designed for the Administration of Therapeutic Exercise"** is described in a new folder brought out by the Elgin Exercise Appliance Co., P. O. Box 132, Elgin Ill. Detailed information on the unit and its parts is given, together with editorial discussion of exercise therapy. A series of photographs illustrates uses of the unit for various therapeutic exercises.

For more details circle #470 on mailing card.

"23 Ways to Cut Food Waste and Labor Costs" is the title of a folder issued by Dispensers, Inc., 947 E. 62nd St., Los Angeles 1, Calif. It tells the story of Dripcut Dispensers and their various uses, with many of them illustrated.

For more details circle #471 on mailing card.

The Contract Division of T. Baumritter Co., Inc., 171 Madison Ave. New York 16, has issued the **Baumritter Contract Handbook.** Illustrations, detailed drawings and photographs tell the story of the full line of institutional furniture manufactured by the company. Construction information in complete detail, specifications and contract policy are given.

For more details circle #472 on mailing card.

• A new 40 page two color catalog on **radiation measuring equipment** has just been released by The Nuclear Instrument and Chemical Corp., 229 W. Erie St., Chicago 10, Ill. The catalog describes the complete line of equipment which includes scalers, count rate meters, Geiger, proportional and scintillation counters and complete radioisotope laboratories.

For more details circle #473 on mailing card.

• A new Manual 54-4 on **Supremo Perfect Seal Cleanouts and Access Covers** is now available from the J. A. Zurn Mfg. Co., Plumbing Div., Erie, Pa. A discussion of Code requirements and the importance of preventing "trouble zones" by the proper selection of locations for installation of cleanouts is given.

For more details circle #474 on mailing card.

• A new 8 page catalog of the entire line of **Acme Cotton Products Co., Inc.,** 245 Fifth Ave., New York 16, N.Y., has just been released. A Table of Contents on the front cover facilitates quick page reference and the items described in concise terms cover a complete range of surgical dressing and first aid supplies.

For more details circle #475 on mailing card.

(Continued on page 256)

What's New . . .

What **L & F Instrument Germicide** does and does not do is told factually and also amusingly in a folder recently brought out by Lehn & Fink Products Corporation, 445 Park Ave., New York 22. The introduction is written with a light touch, in the first person, with the heading "it's a big responsibility being an Instrument Germicide." Data on the action of L & F Instrument Germicide are supplemented by factual information on how and when it is used and how it does not irritate skin, corrode instruments, have a disagreeable odor or require measuring or mixing.

For more details circle #476 on mailing card.

• An 11 by 17 inch card, entitled **"Hand Dishwashing Made Easy by These Five Steps,"** has just been published by Wyandotte Chemicals Corp., Wyandotte, Mich. A simple and practical dishwashing rotation system described on the card speeds the operation, gives better sanitation and is helpful to workers.

For more details circle #477 on mailing card.

• A new edition of the **Stanley Hospital Hardware Catalog** is now available from The Stanley Works, New Britain, Conn. The catalog gives detailed information on the hardware "designed and engineered to meet the most exacting requirements of modern hospitals." Types, applications and construction of the complete hardware line are discussed.

For more details circle #478 on mailing card.

• A new catalog containing full information on the expanded line of **Propper hospital, surgical, laboratory and bacteriological supplies** has just been released by Propper Mfg. Co., Inc., 10-34 44th Drive, Long Island City 1, N.Y. Included in the catalog is the complete line of Propper Sphygmomanometers.

For more details circle #479 on mailing card.

• A new and simplified index to all surgical instruments and supplies is included in the new **"Weck Price List"** recently released by Edward Weck & Co., Inc., 135 Johnson St., Brooklyn 1, N.Y. The surgical instruments and supplies are grouped in their various categories. New numbers have been added and a few changed to accomplish the simplified index.

For more details circle #480 on mailing card.

• Detailed descriptive information is given on the advantages of linoleum, rubber tile, vinyl asbestos tile and asphalt tile in a new **guide to smooth surface flooring materials** available for installation. Recently released by Congoleum-Nairn Inc., 195 Belgrove Drive, Kearny, New Jersey, the guide gives information on the main types of underfloor construction and answers questions about floor coverings. A section on proper maintenance technics is also included.

For more details circle #481 on mailing card.

• A new catalog on **"Mats and Matting"** recently released by The B. F. Goodrich Co., Akron, Ohio, features Koroseal runner matting which is resistant to oil, grease, most solvents and chemicals, and will not crack or chip. Among the other mats and matting described and illustrated are rubber runner matting, fiberized counterway for use behind counters, door mats, office chair mats, corrugated perforated and solid mats, and stair treads.

For more details circle #482 on mailing card.

• A new pamphlet entitled **"14 Aids for the Pharmaceutical Plant, Research Laboratory and Hospital,"** is now being offered by Popper & Sons, Inc., 300 Fourth Ave., New York, N.Y. The pamphlet gives brief descriptions of a number of items for the laboratory, pilot plant and production line.

For more details circle #483 on mailing card.

• A comprehensive catalog covering the full line of **hospital supplies** handled by the company is now available from Mills Hospital Supply Co., 6626 N. Western Ave., Chicago 45. The catalog is divided into fourteen sections, each illustrating and describing products in the various categories including general supplies, laboratory equipment and glassware, sutures and dressings, linens and garments, and the like. Each section is readily referred to through marginal tabs carrying subject headings and since the large catalog is spiral bound it lies flat when opened. The final section is an index listing each item alphabetically by name and by manufacturer.

For more details circle #484 on mailing card.

How the **Electronic Flicker Photometer** helps to detect prodromal pathology before clinical symptoms develop and determine response to prescribed medication is discussed in a new folder released by Clinical Instruments Co., 122 S. Michigan Ave., Chicago 3. Full descriptive information on this new diagnostic aid is given, together with clinical reports.

For more details circle #485 on mailing card.

• **"Correctly Controlled Daylight—Better Light—Better Sight,"** is the title of a comprehensive 24 page catalog just released by L. O. Draper Shade Co., Spiceland, Ind. The catalog gives complete details on the full line of Draper shading equipment, including Draper Sight-Saving Translucent and Durable Darkening Shades. It also carries information on the latest developments by the shade company; the Draper New-Way and the Lite-Lock Type Skylight Unit. Swatches of Dratex Shade Cloth are included. The catalog is profusely illustrated and has a section covering Draper Window Shade Hardware and Sundry Parts, and specifications for window shades and how to measure and order.

For more details circle #486 on mailing card.

• The Aluminum Company of America, 1501 Alcoa Bldg., Pittsburgh 19, Pa., has just released a drawing showing full details of the **architectural use of aluminum as an exterior wall facing material** for a hospital. The drawing, showing the Mayo Clinic Diagnostic Building, Rochester, Minn., is one of a series that illustrates outstanding achievements in recent construction with aluminum.

For more details circle #487 on mailing card.

• A new **Bulletin No. LP 354** has recently been released by Katolight Corp., Mankato, Minn. It describes the new standard line of power plants produced by the company, giving information on each unit including ratings, general features and accessories.

For more details circle #488 on mailing card.

• A new printing of the **"Please Don't" folder** released by The Maple Flooring Manufacturers Assn., 35 E. Wacker Drive, Chicago 1, Ill., has just been announced. The folder explains that problems from expansion of kilndried hardwood flooring caused by absorption can be eliminated if the rules for efficient handling at the job site are followed. Information on the subject of nails, giving the sizes and kinds recommended for fastening Northern Maple and Birch flooring, is included in the new folder.

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• **Air cleaning and control problems** are discussed in a new bulletin recently released by Electro-air Cleaner Co., 1285 Reedsdale St., Pittsburgh 33, Pa. The answer to this problem has been found with the recent development of inexpensive electronic equipment capable of effectively eliminating air-borne contamination. The new bulletin gives complete and detailed information on this equipment including construction features, specifications, dimensions and installation possibilities.

For more details circle #490 on mailing card.

Suppliers' News

Halsey X-Ray Products, Inc., 1425 37th St., Brooklyn 18, N.Y., manufacturer of x-ray accessories and supplies, announces the opening of a West Coast warehouse and showroom at 1911 E. 9th St., Los Angeles, Calif., under the direction of Al Barry & Son.

Will Ross Inc., 4285 N. Port Washing-Rd., Milwaukee 12, Wis., manufacturer and distributor of hospital supplies and equipment, announces the opening of a Southwestern warehouse at 1019 Slocum St., Dallas, Tex. The complete line of merchandise regularly stocked by the company will be accommodated and the warehouse will operate as a complete unit for distribution to the Western and Southwestern states. The operation will be under the supervision of Mr. Jack Howell.

USE THIS CARD

(We pay the postage)

This card is detachable and is provided for the convenience of our subscribers, and those to whom they pass their copies, in obtaining information on products and services advertised in this issue or described in the "What's New" Section. See reverse side.

September, 1954

Please ask the manufacturers, indicated by the numbers I have circled, to send further literature and information provided there is no charge or obligation.

WHAT'S NEW

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NAME **TITLE**

INSTITUTION

ADDRESS **CITY** **ZONE** **STATE**

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National Turkey Federation

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446 Extremity Prep Tray
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448 Safety Sides
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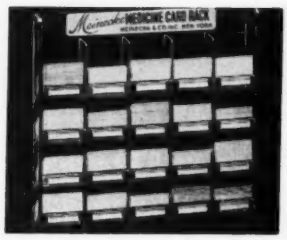

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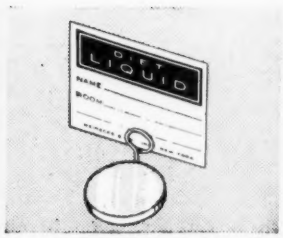

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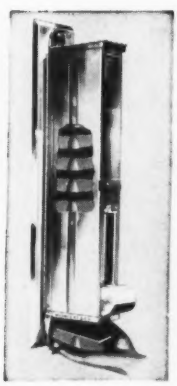

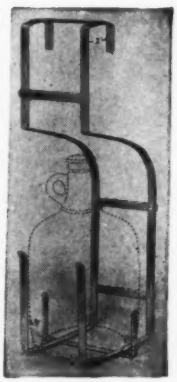

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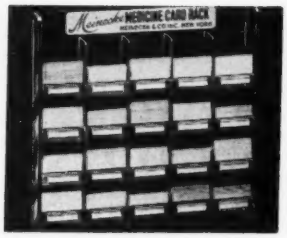

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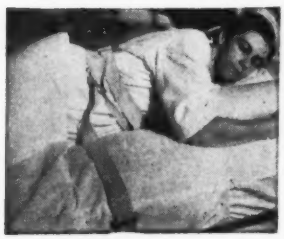

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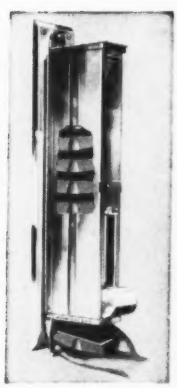

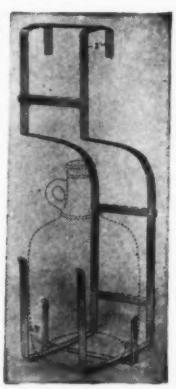

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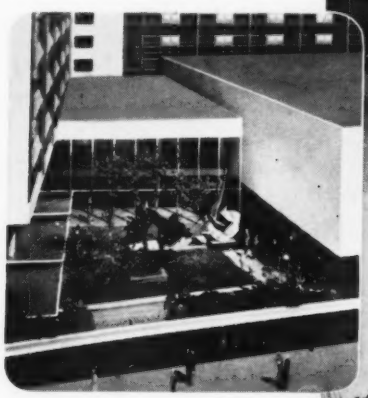

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